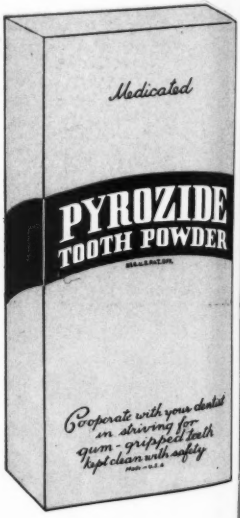
ORAL HYGIENE

Abrasion of tooth structure

usually starts at the gum line after irritation has caused the gums to slightly recede. Wearing away of tooth surfaces progresses in direct relation to the "grinding" action of the combination of cleansing materials used on the gums and teeth.

The tooth enamel is sufficiently hard to withstand "grinding abuse" for considerable time but the delicate gum margins and softer dentine are much less resistant to the action of abrasives

Pyrozide Tooth Powder is especially prepared for brushing the gums to promote needed stimulation in raising resistance to deterioration of these tissues and for cleaning the teeth safely. A two hundred mesh light precipitate of chalk, sodium perborate and magnesia combined with barks reduces abrasiveness to the minimum while increasing the polishing action of the powder. It is medicated with Dentinol to an extent suitable for continued use in a dentifrice.



•

A meritorious product that gives exceptional satisfaction to habitual users.

•

Sold at drug stores generally, due to professional endorsement. No claims advertised to the public.

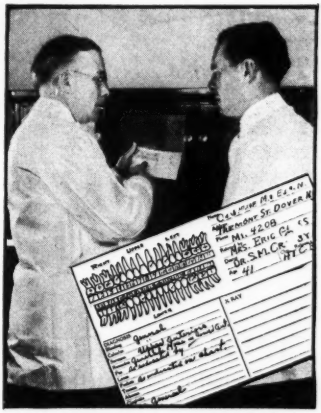
THE DENTINOL & PYROZIDE CO., Inc.

Sole Distributing Agent

1480 Broadway, New York City

"After I operated for PYORRHEA

her recovery was slow... I traced the cause to Intestinal Toxemia"



AN increasing number of dentists prescribe Sal Hepatica after pyorrhea surgery. They know that success depends on maintaining the patient's general physical condition... that proper elimination is the first step in insuring the cooperation of nature with the operation.

Accumulation of toxic wastes retards regeneration of the gingival tissues properly to support the teeth. Recovery is slow.

Sal Hepatica aids in two ways. It gently, yet thoroughly, cleanses the entire intestinal system and improves the patient's general "tone" by helping maintain normal alkalinity of the blood stream.

Being a saline laxative, it corrects calcareous deposits, salivary debris and neuritic and arthritic conditions resulting from an uric acid diatheses and activates the body's natural eliminative functions. Yet, even when prescribed over a long period of time, Sal Hepatica creates no condition of tolerance.

Do your case histories show this same thing?

Let us send you a generous complimentary sample of Sal Hepatica for your own tests. There is no obligation. Just mail the coupon now.

SAL HEPATICA

MEMO to Bristol-Myers Co., 75L West Street, N.Y.C.

Without charge or obligation on my part, kindly send me samples of Sal Hepatica to be used for clinical purposes. (I enclose my card or letterhead.)

*Name*_____ *D.D.S.*

*Street*_____

*City*_____ *State*_____

THE
Publisher's

No. 159

CORNER

By MASS

THIS afternoon I spent a dime for a stray copy of the London *Times* that I found on a newsstand and this evening I've been reading the solid columns of fine type on the front page. At first glance *The Times* looks to be a deadly document, for there are no front page headlines at all, or, in fact, no news on page one—as we understand news. But, lurking here and there in the gray mass of tiny type, you'll find romance and life and color if you look for it.

Your imagination will be stimulated to build stories of perhaps more absorbing interest than you'll find in the headlined front pages of our papers here, as you pause in reverie after reading some of the little closely-set advertisements with which *The Times'* front page is filled—seven deep columns of telephone book type, all advertisements except for the births and deaths and marriages.

The quaint "English" English is the sort you find in Britishers' books, and the place-names conjure mind pictures of England:

"MASTER of POLWARTH would LET HARDEN for few weeks; lovely old house on border moors; fine situation

He prefers it to brands costing much more

How much for a *good* dentifrice?

Our aim has been to offer as fine a dental formula as modern research can produce. . .and to price it as low as our facilities and costs permit.

As might be expected of such a product, Listerine Tooth Paste enjoys a large sale. We hope you will call this dentifrice to the attention of your patients as meeting your idea of things—a thoroughly satisfactory formula at a fair price.

Our new Double Size contains twice as much and sells for 40c—saves 20% more! Lambert Pharmacal Company, St. Louis, Mo.

REGULAR SIZE **25¢**

NEW DOUBLE SIZE 40c

and view; three public, 10 bed rooms; shooting if desired. —Harden, Hawick." You wonder about the Master of Polwarth—a ruddy cheeked chap, no doubt—wonder why he "would let" the lovely old place; you think of his sitting musing about letting strangers come in, pulling at his British moustache, deciding to do it. You wonder who answered, and if they broke anything, and what the Master of Polwarth said if they did.

"Mrs. FREMLIN, of Little Paddock, Rowledge, wishes to thank all those who have SENT MESSAGES of SYMPATHY to her in the great sorrow of the death of her son." A story there in the twenty-nine tear-stained words written for *The Times* front page by a broken-hearted mother in Little Paddock.

And the germ of mystery in these two lines heading one of the seven gray columns:

"B. ANNE:—Wire rcvd. too late, sent already. Very sorry, hope O.K., awaiting instructions." What was sent and what is happening? Is Anne in hiding? Why must *The Times*' front page be used for a post-box?

There's more mystery in the next two lines:

"Grateful thanks to St. Jude Thaddeus for success in Examination.—R.C."

Even the British big wigs write some of their letters here: "CONSCIENCE MONEY.—The CHANCELLOR of the EXCHEQUER ACKNOWLEDGES the receipt of £5 from T.J.A." What led T.J.A. to render unto Caesar, and did his own unstable character suggest that maybe the Chancellor was unstable, too, so did T.J.A. *require* that the five pounds be receipted for in print? Or did the Chancellor insert these few lines in *The Times* front page as a matter of course, in the spirit of true British thoroughness?

Try to picture Mrs. Gigney and her English garden:

"LAVENDER, 5s. 1,000. 3s. 500; long stalks; post free.—Mrs. Gigney, Old Walshoken, Wisbech."

And they can book me for a while at Sam and Eileen Crocker's, with the lovely long address: "DARTMOOR, Cherry Trees, Belstone, Devonshire; excellent cooking, late dinner, separate tables; Heal's beds, acetylene light, constant hot water; garage; charming garden to moor; baths; morning tea; coffee; fresh fruit; newspapers; note paper included.—Proprietors, Sam and Eileen Crocker, Telephone Okehampton 64."

And, further along in the gray acre of small type, you begin to wish you could spare £240: "MASTER MARINER and THREE MATES (B.O.T. certificates) unshipped owing to depression and now becoming desperate through unemployment, have opportunity of acquiring small AUXILIARY VESSEL for £240. If any sympathizer will ASSIST PURCHASE, four sound seamen will have useful and profitable scope for their labour.—Box S.1217." You can see those four sailors, tightening their belts, pooling their pence to pay *The Times'* rate. And did they get their boat, I wonder.

Or imagine for yourself this crisis in a castle: "PEER'S DAUGHTER, 25, REQUIRES POSITION early in September; salary essential.—Box S. 1240."

And who could have paid for this, heading column four? "Let us therefore not judge one another any more: but judge this rather, that no man put a stumbling-block or an occasion to fall in his brother's way.—Romans, xiv. 13." Just that and nothing more.

But here is one to *answer*: "INFERIORITY COMPLEX? Write for free book, 'I can. . .and I will.' British Institute of Practical Psychology, Ltd., 1 Ludgate Hill, London, E.C.4."

OCTOBER, 1934 VOLUME 24, NO. 10

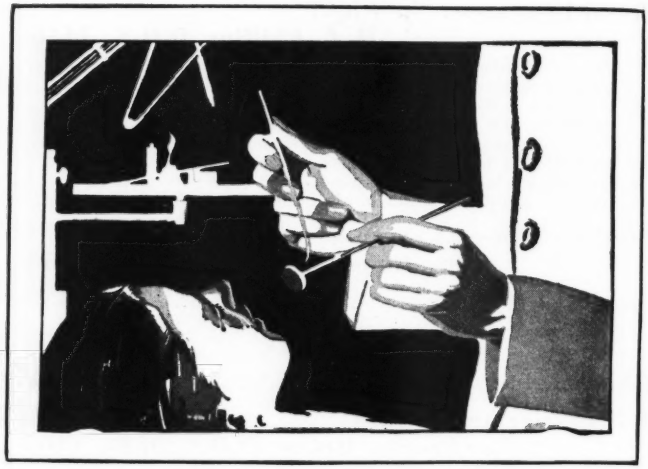
IN THIS ORAL HYGIENE

(CONTINUED ON PAGE 1423)

(CONTINUED FROM PAGE 1420)

Edward J. Ryan, B.S., D.D.S., *Editor*
Rea Proctor McGee, D.D.S., M.D., *Editor Emeritus*

PUBLICATION OFFICE: 1005 Liberty Ave., Pittsburgh, Pa. Telephone, Atlantic 4670. Member Periodical Publishers Institute. Charter Member Controlled Circulation Audit.
Merwin B. Massol, Publisher; Associates: J. J. Downes, J. W. Kaufman, R. C. Ketterer, W. Earle Craig, D.D.S.
CHICAGO: W. B. Conant, Vice President and Western Manager, Peoples Gas Bldg. Telephone, Harrison 8448.
NEW YORK: Stuart M. Stanley, Vice President and Eastern Manager, 18 East 48th St. Telephone, Wickersham 2-1744.
ST. LOUIS: A. D. McKinney, Southern Manager, Syndicate Trust Bldg. Telephone, Garfield 0043.
SAN FRANCISCO: Don Harway, Pacific Coast Manager, 155 Montgomery St. Telephone, Exbrook 6029.



30 Reasons
WHY PEOPLE STAY AWAY
From Dentists

By HOWARD R. RAPER, D.D.S.

THESE facts I believe are self-evident: that people *do* stay away from dentists, and that this is undesirable for both the people and dentists.

Since the condition is an undesirable one, it should be corrected if possible. The first step in its correction is, I think, to discover and analyze causes. In other words, the first thing to do is to make an analytical diagnosis.

I should, I feel, make it quite clear at the outset that I have no panacea to offer. This discourse is essentially diagnostic in character. However, as is true in the prac-

tice of medicine and dentistry, the making of the diagnosis sometimes itself suggests the treatment.

The substance of the discourse that follows was presented last year as a lecture before the members of the Indiana State Dental Association, my particular friends. At times it is deliberately intended to be provocative. I hope those readers who know me less well than the dentists of Indiana will accept what I have to say with the same good humored understanding displayed by my Indiana friends.

Thirty Reasons

First, let me simply enumerate the list of thirty reasons why people stay away from dentists. Later, each reason will be discussed as fully as its importance seems to require. The reasons are set down at random, not in the order of their decreasing importance. The list now follows:

1. Because, first of all, nobody *wants* to go to the dentist.
2. Because of the current economic depression.
3. Because people resent dental bills.
4. Because people are genuinely afraid of dental bills.
5. Because so few dentists have made a genuine and sincere effort to fit the patient's dental service to his ability to pay.
6. Because of the fear of pain.
7. Because people are intolerant of discomfort.
8. Because of a belief on the part of the people that no matter what condition one allows his mouth to get in, a dentist will be able to fix it up as good, or better than new, for a cost that he can afford to pay.
9. Because of the actual efficiency of the profession in repairing dental damage, from an esthetic standpoint at least.
10. Because of the widespread belief that everybody must have artificial teeth sooner or later.
11. Because people are afraid dentists will "bore holes in sound teeth" and do other unnecessary work for them for profit.
12. Because people have been told that certain teeth must come out or they will get sick, go crazy, or suffer

great agony, and, having postponed acting on the advice, have discovered that none of these dire calamities have overtaken them.

13. Because of disagreement in the profession as to the danger of certain teeth to health.

14. Because dentistry has failed in its care of children.

15. Because dentistry has failed to prevent pulpless teeth.

16. Because dentists have not assumed the obligation of reminding patients to return.

17. Because dental preventive measures are directed toward preventing caries and not toward preventing toothache, and because people therefore pin their faith and hope of prevention on toothbrushes and dentifrices, not on dentists.

18. Because so few dentists will really assume responsibility and practice effective prevention—prevention of toothache and the ills that follow it I mean.

19. Because there are so many palsied handpieces and dull burs.

20. Because people have been promised too much and have received too little.

21. Because dentistry is practiced too much in favor of the dentist and too little in favor of the patient.

22. Because people are a little suspicious of dentists.

23. Because dentistry has failed in every publicity campaign it has undertaken.

24. Because so much dental publicity is saturated with insincerity and selfishness.

25. Because people are fed up on health blah.

26. Because people do not realize that toothache is a disease and marks the entrance of disease into the body by the dental path. (When I speak of toothache in this discourse, I mean pulpitis, septic pericementitis and periapical osteitis, the most common of the pathologic conditions that cause the pain known as toothache.)

27. Because of the belief that toothache is inescapable.

28. Because people are not afraid of a decayed tooth.

29. Because people have not been given a good, sound, simple, convincing reason for going to dentists when not

"Broadly, there are two reasons for going to the dentist. One is to keep out of trouble, the other is to get out of trouble."

in pain, and because they are not afraid to stay away.

30. Because neither the profession nor the public can quite realize that caries is a disease and that filling is a treatment for disease.

And now we come to a discussion of the various reasons.

1. Because nobody wants to go to the dentist.

Nobody in his right mind wants to go to the dentist. Why should he? Do you want to go? Do you like to go? What do you like about it?

A man (or a woman) might want to go to a psychologist for the fun of talking about himself or to a chiropractor to have his back rubbed—even dogs and cats like to have their backs rubbed—or to the family physician in the hope of getting a sugar pill or being told to go away on a long vacation. But there are no such mitigating circumstances about going to the dentist. Even Elmer Best's publicized radio attachment to the dental chair might prove to have an opposite effect to that of attraction for some people.

Since nobody wants to go to the dentist, the surprising thing is not that so many stay away but that so many go. Why do they go if they do not want to?

Broadly, there are two reasons for going to the dentist. One is to *keep* out of trouble, the other to *get* out of trouble.

Nothing need be said about getting out of trouble. People need no urging to go to the dentist when in pain or

discomfort. A dog will come to his master to have a thorn pulled from his foot. But the practice of dentistry should be above the dog thorn level, although it has been slumping badly in that direction for the past several lean years.

Why do people, neither in pain or discomfort, nevertheless go regularly to dentists, for there are many such people. The answer is simple. It is because they are afraid to stay away, afraid of the consequences of staying away. They go for the same reason they are vaccinated, not because they want to be vaccinated, but because they are afraid of the consequences of the lack of vaccination.

So, if we want more people to go to dentists, when not in pain or discomfort, we must create in them a greater fear of the consequences of staying away.

Thus a delicate situation develops, for to teach or create fear is a serious business. To plant fear about health in the minds of people when there is not sufficient cause, is quackery, pure and simple.

On the other hand, to create a fear concerning health where there is good reason for the fear, and when its creation enables those having such fear to protect themselves against disaster, is one of the highest forms of medical service. For examples, the fear of typhoid (house) flies and yellow fever mosquitoes has been necessary to the management and control of these diseases.

People are not sufficiently afraid of dental caries. It is not only permissible, but in the nature of a public obligation, for dentistry to teach a greater and more fearful respect for the disease, dental caries; a disease, which, if neglected, may eat its way into the pulp, the bone, and so to the vital internal organs of the body.

2. Because of the current economic depression.

The most potent single cause for people staying away from dental offices is, I believe, an economic one.

What to do about people who actually cannot afford dental service is a social and political problem beyond the ability of the profession to solve unaided—and, since government has been unable to eliminate poverty, it would seem to be beyond the ability of the rulers of countries to

solve also. I do not mean to say that the problem will never be solved, but I observe that it never has been.

It is sometimes suggested that dentists solve it by charity, like general surgeons. No matter how willing and generous dentists might be, no solution lies in this direction, because of the time element. I have in mind, as I write, a dental case in which there were thirty cavities in the teeth. It is not overstating the case to say that a general surgeon might take care of literally a score of people in the time required to carry out the necessary dental operations for this one person.

While it is true that finances are a prime factor, the way people stay away from dentists is not in direct ratio to the actual economic necessity of foregoing dental service. One of the first things people do when even a little pressed for money is to decide to postpone dental work. Thus, the way people stay away from dental offices is in excess and out of all proportion to the actual need for staying away.

For example, a patient is, let us say, in need of certain dental work consisting of several fillings and bridgework. His financial condition is such that he cannot afford to have all of this work done. He has enough money to have the fillings or the bridge, but not both. Under circumstances such as these, instead of going to the dentist and having done what can be done, what needs doing most, the patient usually stays away altogether.

There is too little discrimination between the kinds of dental work. Dental work is just dental work to the people, and even we of the dental profession do not discriminate as we should. The truth about the matter is that some dental conditions require immediate attention, while others may be postponed with comparative or complete safety. Broadly, the filling of a cavity should not be postponed; the making of a bridge may be.

Do not tell me that unless the bridge is made teeth will extrude and drift. I know it. But the making of a bridge is not an emergency operation in the same sense that the filling of a cavity is. And please do not tell me that it might be, for we both know that such a case would be the

exception, not the rule. Let me put it this way. I know of many cases, not a few of them in the mouths of dentists themselves, where the making of bridges has been postponed for years, without any particularly disastrous results. Every cavity in a tooth is an emergency and should be treated as such.

It would be much better for both the people and the profession if there were a freer admission among dentists that some kinds of dental work may be postponed and a greater emphasis on the fact that other kinds dare not be. The result of such admission and understanding would be that more people would, when under financial stress, go to dental offices for emergency care instead of staying away altogether.

Let us return for a moment to the man needing fillings and bridgework. Let us suppose he goes to a dentist and tells him that he has only a limited amount of money to spend on his teeth. Would the dentist fill the cavities or make the bridge? There is no doubt about what he should do—and very little doubt about what many would do, if you know what I mean. And therein, perhaps, lies the real reason why the patient stays away.

Cavities should be filled before bridges are made (except where the cavity is involved in the bridge). It is an old principle of practice, but one which is grossly violated. In my files, I have bite-wing radiographs of newly-set and very good dental bridges, one from the clinic of a dental college, showing the bridge biting against teeth with large proximal cavities.

It is not surprising that dentists prefer making bridges to making fillings. It is more remunerative. Nor is this all. Filling teeth is laborious and nerve-wracking and often calls for the exercise of the highest degree of dental skill, but the people are, for the most part, unaware of these facts and they are often surly and resentful in their attitude toward honest fees for honest fillings. There is much less complaint about the fees for bridgework than about those charged for good fillings.

(*To be continued next month.*)

Albuquerque, New Mexico

I Refuse to SHUDDER

By MAURICE S. CALMAN, D.D.S., LL.B.

I READ and reread the article on Socialized Dentistry by Doctor Wallace G. Campbell,[1] in the August, 1934, issue of ORAL HYGIENE, but for the life of me I could not raise a single shudder at the dire consequences the author predicts should the practice of dentistry actually become socialized.

Right at the outset I want to state that I am stock, lock, and barrel for socialized dentistry. Our profession to date having failed to devise a method whereby the blessings of our calling could be enjoyed by all those in need of dental services, society must, therefore, find a better agency to accomplish that result. In a sane state of society, health should receive first consideration, education next, and business third and not as we now have the process reversed. What better agency than the government could society then employ to extend dental services to all those in need of them.

I note the doctor mentions "public kindergartens, nurseries, swimming pools, playgrounds" as some of the things the government now provides. I wonder why he left out the public and the higher educational school system? Education, not so long ago, was a privilege only the few could pay for and obtain. When the agitation for universal, free education first made its appearance in some localities and later became widespread, history tells us how horror stricken the well-to-do and conservative elements became. All they foresaw was "a bleak, discouraging prospect, a farewell to progress" to quote Doctor Campbell. The conservative press feared that the burden would fall on the rich already frightfully overtaxed; that the coming generation, all becoming educated, there would be no one to do the 'dirty' and hard work; that it would break

[1]Campbell, W. G.: A Discussion of Socialized Dentistry, ORAL HYGIENE 24:1124 (August) 1934.

up the home because the government would interfere with the right of the child to work and contribute toward the family maintenance. Many indeed were the arguments advanced by the opponents of the public school educational system, but, in spite of it all, this system did come about, and we are all the happier for it. I am certain that even Doctor Campbell would oppose a movement to abolish our free educational system, though far from perfect and still admitting "political dishonesty... with official greed and incompetence," and go back to the former individualistic form of private education.

The doctor admits that "It is not hard in these days to find a dentist, whose income does not keep pace with his expenses, getting whatever he can —which often means nothing —from the remnant of a clientele that formerly paid him well." Compare that with the assured income the public school teacher, the letter carrier, and the many thousands of other public employees receive, week in and week out, and honestly state which form of income the average dentist would prefer today?

Socialized dentistry does not necessarily presuppose a system that will completely abolish private dental practice. Even in Russia where dentistry and medicine have been socialized, private practice still obtains. This is equally true of education. With the introduction of the public and high school educational system, the private schools have continued their existence to this day.

Doctor Campbell expresses a fear that socialized dentistry may gain "a real foothold here," or if it "ever attains a position of importance in this country," two things he fears most: 1—"the stifling of genius, the loss of the incentive to excel," and, 2—"bureaucratic control, with its red tape and wearying routine."

As to the first, under the admitted depressing economic conditions, what are the prospects for one to express his genius or overcome the deadening effect on his incentive to excel? Are these virtues not more readily possible under a system of socialized dentistry where one's income is assured, thus removing a primal factor to stifled genius and lack of incentive? Why cannot the government under socialized dentistry maintain laboratories where dentists possessing genius may be given an opportunity for developing and displaying it? It is being done at present in varied governmental departments—agriculture and husbandry—to mention but two. Also, an assured income, to my way of thinking, is a greater incentive to properly serving our fellowmen, than an haphazard one.

As to the second fear. I agree with Doctor Campbell that there is danger in "bureaucratic control." But why should there be such control? Why not admit that some form of socialized dentistry is in-

evitable, and then give your time toward the propagation of a plan for control of this governmental activity by and through organized dentistry?

Until some more feasible plan than socialized dentistry can be thought out, which would benefit both the people and the dentist, we shall continue our campaign of enlightenment with a view to converting more and more people to our way of thinking and until socialized dentistry becomes a fact. Believers in the status quo are urged to open their eyes and they will find out that all about them the world doth move.

600 West 181st Street
New York City

MAKING COLLECTIONS

Prompted by his interest in the article, The Collection Racket Exposed,[1] to send ORAL HYGIENE a report of his own experience in collecting delinquent accounts, Doctor Herbert Ely Williams, 120 Broad Street, Red Bank, New Jersey, writes:

"I have a representative who handles my delinquent accounts, and she has collected more for me within the last eighteen months than I have ever realized from all collecting methods combined during my long period of practice.

"Personal contact helps solve the bill collecting problem. Frequent mailing of bills contributes liberally to Uncle Sam for stamps and to the paper industry for stationery. A personal representative, preferably a woman with personality, tact, and uncommon sense, is by far the best person to collect old accounts. A man debtor—a gentleman—will never offend a woman. He would prefer making payments to having her on his trail. Her commission of 25 per cent makes collecting satisfactory to her and to the dentist, because he receives the other 75 per cent. Many collectors apparently believe that all of the proceeds of their efforts belong to them—to have—to hold—to keep. It is frequently more difficult to collect from a bad collector than from a fair debtor. Many dentists resort to the suit and judgment plan, but how many dentists have retired from practice on the proceeds of judgments? Common sense and personal contact are fitting companions in handling delinquent accounts."

[1]Brock, F. W.: The Collection Racket Exposed. ORAL HYGIENE 24:1138 (August) 1934.

I'm Going to Change

MY DENTIST

BY A DENTAL PATIENT

I'M going to change my dentist. The climax happened on my last visit. My watch had stopped and I had an important engagement, which I missed because the clock on my dentist's desk was twelve minutes slow. I could have forgiven him if this were his only dereliction. But it wasn't. The real reason is summed up in one word—cleanliness.

Now I'm not a bug on cleanliness, but at least I like to see in a professional office the same standard of cleanliness as I maintain personally and in my own home. My dentist is a nice chap—comparatively young—eleven years' experience, according to his diploma hanging on the wall in a dusty frame. He's a good dentist, in my opinion. Takes pride in his work, too—but, alas, not in his appearance. Wears during office hours a white (?) jacket and trousers. White, I presume, when first put on, but after a while, if he were mixed up with a lot of D.S.C. men I'd have a difficult time locating him by his attire.

He wears a mustache and always seems to need a haircut or shave or both. I like mustaches, but when he touches his with his fingers and then works on my mouth without washing his hands—well... His hair moves over his forehead a la Napoleon, and his fingernails are dirty. One day he demonstrated on *my* mouth with *his* fingers how I should massage my gums. I gargled when I got home.

His shoes invariably need a shine and his soft collar and shirt are seldom clean and fresh looking.

His office, too, has that "anything will do" appearance. Both the waiting room and operating room need the energetic application of soap, hot water, and "elbow grease." Dust can be seen on the mirrors, furniture, desks, lamps, and dental equipment. The windows and curtains are dirty. Ash trays are full of cigarette ends. Some magazines are a year old. The nickel on the equipment needs polishing and all his instruments look as if a thorough cleaning wouldn't

do them any harm. Oh, yes, he boils some of his instruments before he uses them, but he places them on a dusty tray. I had a porcelain filling put in and the saliva ejector looked as if it were some old gas piping.

Yes, he has a "nurse," or at least a young lady dressed in the uniform of a nurse. She doesn't assist him in the operating room; she makes appointments and keeps the accounts, I suppose. But I would never have engaged her, because her complexion is terrible, no matter how much she attempts to camouflage it. Obviously she has some skin disease—probably harmless—but she is hardly the wisest choice for a dentist's office.

I was inwardly amused the last time I went for treatment. On his desk I noticed a book entitled, "101 Ways to Get More Patients." These days, I'm reasonably sure, it's harder than ever to get new patients, and so it seems to me a great pity to lose a patient because cleanliness—something charming in itself, and especially desirable in a dentist and his office—is conspicuous by its absence.

How Does He GET THAT WAY?

By FRANK A. DUNN, D.D.S.

THE college professor can give it, but can he take it? Why not try him out for a few rounds? The answer will be, "He can't." He has played an arrogant, bulldozing, unfair part too long. His opponents have been handcuffed and blindfolded push-overs whom he could safely low-punch, rabbit-punch, right-cross and double-cross.

Could restaurant owners talk to dishwashers, waiters, and cooks the way college professors talk to students? They could if they didn't mind crockery, cleavers, pots and pans bouncing off their heads. What is more, the dishwashers, waiters, and cooks get good money for what they give, while the students give good money for what they get—and take. And how they can and do take it!

Chinese coolies might stand the abuse the students take, but no self-respecting shop mechanics, office clerks, or store clerks would put up with it from their bosses for one minute; nor would the dishwashers, waiters, and cooks just mentioned.

Why do the students take it? Many of them have worked temporarily in offices, shops, and stores, where they were shown courtesy and kindness, and were paid good money to boot. Yet they will sit in a classroom before a medical school professor, to whom they are paying good money, and let him sneeringly refer to them with, "D.D.S.—dirty dental students." That is not imagined—it was, and perhaps still is, the common remark of one professor.

Can you picture any dental supply company official addressing his employees as "dirty dental salesmen"? You certainly cannot unless he were drunk or had gone suddenly insane.

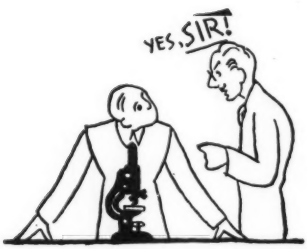
Remarked a senior dental student who had a far finer mind than many faculty members and professors, "I started with a wholesale grocery as a sort of junior clerk and worked up to a rather good position. I was with the company for ten years and during that time I had a number of different bosses. Everyone of them

"Could restaurant owners talk to dishwashers, waiters, and cooks the way college professors talk to students?"

treated me with utmost courtesy and consideration. What a jolt I got when I quit and entered dental college. One day a squirt of a medical school professor, because I couldn't correctly answer a question, sneered before the class that he had a twelve-year-old son who knew more than I did. I met with more mean and crude stuff of that sort around a college in one week than I did during the whole ten years I was in office work."

A freshman in chemistry became tangled among some denominators and what he called numiniators—who hasn't a few twisted words like that tucked away in his head? The assistant professor glared at him contemptuously and bitingly asked, "Haven't you ever gone to school?" That assistant professor was probably getting fifty dollars or less a month. The student had been a well-paid stenographer to various railroad officials..... in fact, just previous to the denominator-*numiniator* mix-up he was stenographer to the president of the New York Central Railroad at one hundred dollars a month (big money for those days)..... and no railroad official, high or low, had ever spoken to him, even remotely, like that assistant professor.

Cowardly and petty parts were played by those two so-called professors. It was like striking a man who was completely helpless.



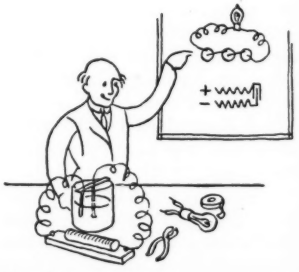
"Yes, I can see them clearly," answered the student. "Yes, SIR, I can see them clearly," commented the professor.

The student was looking into the microscope. "Can you see the cells?" asked the medical school professor. "Yes, I can see them clearly," answered the student. "Yes SIR, I can see them clearly," commented the professor with a sneer in his voice. He wanted that servile *sir*, as if the student were a porter or a bellhop. Can you imagine an office man descending to such rot?

The professor looked at the carved wax partial denture. The student had put his heart and soul into the making of that piece. In spare time and time not so spare he had worked for hours over the clasps and rests until he believed he had them just about right. The professor held the piece in his hand. He might have suggested that the clasps or rests were improperly made or something of that sort, and added a word of encouragement. But he didn't. With an ape-like grin and a hyena-like disposition he crushed the denture in the palm of his hand. "Make it over," he rasped. "That dirty swine," said the student later (a pretty c o m b i n a t i o n—ape-hyena-swine) "never knew how close he came to having some of his own teeth smashed in. I would have been kicked out of college, but a good punch at him might have been worth it."

Another professor of this same breed gave a course in electricity. You may ask, "Why electricity? Why not horseshoeing?" Probably because the professor was a better electrician than horseshoer. But there was the course, and no comedy about it—it was tragedy.

Ramming a deep knowledge of ohms, watts, and amperes into the students was supposed to bring extraordinary benefits, even if, at the end of the course, not one of the sixty men in the class could repair an electric doorbell. And *ramming* is right. Numerous hours each week had to be devoted to ohms, watts, and amperes and



"Another professor of this same breed gave a course in electricity. You may ask, 'Why electricity?'"

what went with them or the students would figuratively be kicked all over the place; and at the same time maybe thirty minutes or less a week might be spent on such subjects as root canals, exodontia, anatomy of the head, and so forth. In class one day a student told the professor that he wasn't prepared on electricity because he had an extra examination coming up that day on histology and had given all of his time the previous few days to that subject. "Leave the room," exploded the apoplectic nincompoop. And the student went slinking like a whipped dog toward the door.

"Talk about being taken for a ride," remarked a dentist ten years in practice, "I signed up for a course in public speaking at the college. One lesson was enough—it was the same old bullying, belittling stuff—I surely did want to sock that professor on the nose."

That is the way it is in every college—save business colleges. A business college is there to make money. The president knows that a bulldozing professor on the staff is a handful of tacks on the seat of learning. The professor doesn't try it because he knows he cannot get away with it.

The experiences I have mentioned were not isolated or unusual. Of course, one may have a sharp temper that he thinks he cannot control, like a certain mate on a whaling vessel. The mate had knocked down a sailor, broken his nose and jaw, loosened his teeth and blacked his eyes. The captain noticed the sailor's terrible condition, and asked the mate about it. The mate said he had a quick, uncontrollable temper and that he had beaten up the sailor more than he had intended. The captain looked contemptuously at him and growled, "So you have a quick, uncontrollable temper, eh! Why you dirty scum, you blasted brute, you ought to be flogged yourself." The mate stood with bowed head while the captain glowered at him for a minute, and then from the captain, "Why don't you lose your uncontrollable temper now?"

"Why don't you lose your uncontrollable temper now?"

Roughneck dock bosses and other bosses with a bit of power used to yell, "Hey, you fathead, hustle up or I'll bust your face in." But it was found that more work and better

work was done when that sort of thing was no longer permitted. There is marked similarity between the roughneck bosses and the bulldozing college professor.

Still, occasionally the students can turn, the same as other worms. There was a medical college professor who reveled in humiliating the students and grasped every opportunity to show his contempt. When the abuse could no longer be endured, the worm turned. The students appointed a committee to wait upon the president of the university and demand either decent treatment or the removal of that professor. Did the professor throw back his shoulders, push out his chest, and take it as he had given it? He did not. He all but crawled on his hands and knees to beg the students not to insist on his removal. One dose of that medicine effected an immediate cure. It might be well to try a few forced swallows of it on others.

How does he get that way? He starts out by landing a sarcastic jab on the student's nose. There is no comeback. His ego is tickled and swelled by this power over his inferior fellow creatures. He follows with slaps and blows, and soon he is playing a sort of Simon Legree part to the student's Uncle Tom. He does it simply because he can get away with it. Certainly he doesn't get that way because of any unusual intellectual capacity. Let him talk about anything, even his own specialty, and three-fourths of what he says will be twaddle, three-fourths of what he writes will be more twaddle. Even if he thoroughly knows his subject he will stand before his class and present his material in jerks and jumbles. He has no talent for telling things interestingly, and he has never tried to develop such a talent, with the result that his teaching is more befogging than enlightening.

Thousands of men in the profession are not members of organized dentistry. Why? One reason may possibly be found in their college experiences. They have had three or four years under some of these petty-minded professors, and after they have been graduated they do not care to renew the association in dental societies.

Still, the dental professor proper, that is, the professor who is a dentist, is unquestionably the best of them all. Invariably he is kindly and courteous, although some of the mean, arrogant type will be found on many teaching staffs. Regardless of the honors such men may have won, they are a liability instead of an asset to any college—and to any profession.

(Certain readers may take offense at these comments and construe them as an attack on men whom they honor and to whom they feel deeply indebted. Not one line set down here is intended as an attack on such men. In my day in college there were professors

whom I certainly honored and to whom I felt deeply indebted. There were three nationally known dentists on the faculty who were gentlemen in the truest meaning of the word, men who were always considerate and helpful and possessed of the finest human and humane qualities. And there were a number of younger men on the faculty who were deserving in every way of the highest praise.)

Five years ago I was to address the students of a preparatory school. The principal, who had been a college professor, was a fine old friend of mine and a thorough gentleman. At various times he had listened to me air my views on some educators.

He introduced me to the audience with exceedingly pleasant remarks, but he had considerable trouble with facial contortions when he concluded with, "Whatever success Doctor Dunn has had in life he owes to the gentleness, to the kindness, and to the splendid teaching in his younger days of his college professors."

8916 Superior Ave.
Cleveland, Ohio

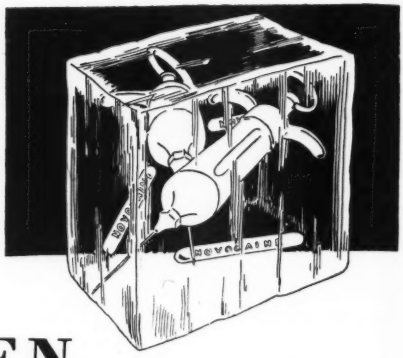
DENTAL COLLEGE DEFINED IN OHIO

In line with the general trend toward more stringent requirements in dental schools, the Ohio State Dental Board has recently prepared a definition of a reputable dental college, according to an announcement by Doctor Morton H. Jones, Secretary.

Requirements for a reputable dental college as set down by the Board are: a minimum course of study leading to graduation, two years of pre-dental study, and the successful completion of a full four-year course in professional dentistry under the direct supervision of the dental faculty of a dental college in the United States.

"The two years of pre-dental study," the statement continues, "shall be obtained in an accredited college of liberal arts or an accredited college of a similar nature and must include English, 6 semester hours; phyiscs, 6 semester hours; animal biology, 6 semester hours; and chemistry, 12 semester hours. The four years of dental study shall be obtained in a college of dentistry whose entrance requirements are in accord with the above described two years of pre-dental study, and shall comprise four full school years of dental study in such dental college under the direct supervision of a dental faculty. Credit for not more than one year in the dental college may be granted to those having graduated in an accredited medical college.

"The Ohio State Dental Board reserves the right to interpret the requirements for pre-dental courses of study."



FROZEN ASSETS

By R. Bullock Jones, D.D.S.

THE constant use of procaine in virtually all phases of dental operative work has been the biggest single factor in maintaining for me a sizable practice during these last three years. Here, indeed, is a great practice-builder, and yet the dentists who use procaine in this manner are still in the minority.

It is apparent from a review of dental literature that American dentists do not use procaine as extensively as dentists in Europe. This may be on account of the fact that American dentists have become familiar with the use of nitrous oxide and have found it a sure and infallible means of alleviating pain during operations. On the other hand, if information gained from many of my patients is true, all too many dentists are letting their patients have plenty of the thing they most fear in the dental chair—that is, *pain*. More patients tell me that they have changed dentists because they were hurt rather than because their work hadn't been well done.

As a matter of fact I am convinced that only a small percentage of our patients know what good restorative work is. Certainly, those of our patients who are children or adolescents don't know what it is; our mature patients seem to want work that will keep them comfortable for a few years more.

This leaves the young and middle-aged adults to be considered. I am willing to wager that you'll find some poor work in 90 per cent of this last group. That should mean, in most instances, that they don't know it is poor work. This may sound heretical, but keep in mind that I don't wish to condone poor work. I am simply making an observation with which you may or may not agree. However, you will agree that all patients know and remember whether they have been hurt.

I can recall only one exception and that was the young, dreamy-eyed college student who said, "There hasn't been enough pain in my life, and I believe occasional pain is good for the soul. I want you to hurt all you can." I accommodated him just for the sake of variation.

Recently, during office routine, a typical patient made a typical remark. I think it is worth repeating. The patient, a middle-aged woman, lived twenty-two miles from my office. She said:

"I met two women on the street today as I was leaving for my appointment. One asked me why I didn't patronize our new local dentist since everyone said he was nice. I told her I had found a dentist whose work was very acceptable because I was able to permit him to do it thoroughly. The other informed me that she was glad she didn't have a dental appointment; they gave her the shivers. I told her that you were the first dentist who had ever given me novocaine for fillings, that my dental appointments were now absolutely painless for the first time in all these years and that I came to you with no more apprehension than when going to the hairdresser."

Maybe you aren't as vain as I, but I seem to thrive best on such praise. It seems to bolster up my morale; makes me feel I am rendering a worthwhile type of service and sharpens up my ego just enough to help me over the tough spots.

But, whether you need similar stimulation or not, you do need income and to get that you have to attract patients and hold them.

Occasionally, when I am explaining the use of local anesthesia to a new patient, he will say something like this:

"The last dentist I went to said it wasn't safe to use novocaine and that it not only made a lot of people sick, but in many cases killed the nerves in the teeth."

I believe such a statement is a defense mechanism adopted by the dentist to justify his inability to use procaine correctly. Of course it is safe to use. It isn't safe to drive a car unless you have learned the technique but that is no reason to condemn the driving of automobiles.

Anent the safety factor I wrote the following letter which was published in the *Journal*

"I can recall only one exception and that was the young, dreamy-eyed college student who said 'There hasn't been enough pain in my life. . . .hurt all you can.' I accommodated him just for the sake of variation."

of the American Dental Association[1] in January, 1934:

To the Editor:

Doctor R. M. Waters has made an excellent contribution to our dental literature on procaine usage in his article on "Procaine Toxicity"[2] which appeared in the December issue of the *Journal*. His summary on "combative treatment" should be placed on file in a readily available notebook in every dental office where procaine is extensively used.

While I feel that thorough knowledge of the above is necessary, I disapprove of placing too much stress on the possibility of severe reactions in ordinary dental usage of procaine. It is quite probable that Doctor Waters (a physician) would find more evidence of severe reactions in his clinical observation than the dentist. I am thoroughly convinced that procaine should be used freely in the normal operative pursuits of the general practitioner of dentistry.

If observations on procaine usage in this section of New England are typical of all parts of the country, then the general public is not being granted the blessings of procaine in the degree to which it is entitled. There must be several reasons why it is not used more extensively in the thousand

[1]Jones, R. B.: Procaine Toxicity, J.A.D.A. In Correspondence department **21**:188 (January) 1934.

[2]Waters, R. M.: Procaine Toxicity: Its Prophylaxis and Treatment, J.A.D.A. **20**:2211 (December) 1933.

and one instances where its usage is indicated. Timidity probably is one cause. If you give a timid dentist a vivid imagination (and he generally does have) and let him read Doctor Waters' word picture of what to do in case of a severe reaction, he probably will pat himself on the back for not using procaine except when he is forced to.

In my office, over 2,000 injections of procaine *a year* have been made for the past *three years* without one severe reaction. Is that luck? It may be, but I think not. It is more apt to mean obeying the simple principles outlined by Doctor Waters in his article. Slow, deliberate injections are absolutely essential; avoiding intravascular injection is equally important and not difficult to assure in most instances.

Doctor Waters comments on the use of a barbiturate (brief action) as a premedication in using procaine. This, too, is an important aid. We have been using routinely a one and one-half grain capsule of sodium pentobarbital administered one-half hour before the appointment, preferably in the office. When circumstances would not permit its use we have had no hesitancy about proceeding without it if there was no unfavorable physical history. But we *always* use a solution with a minimum epinephrin content. In some instances, our anesthesia will depart before we have finished the cavity preparation or what not, but it is easy enough to repeat the injection. My patients want procaine; they like it and soon they will demand it.

I quote this letter in spite of the fact that it was not my intention to touch upon technique. I do so because some dentists have told me they were afraid to use procaine as a routine measure and thereby are robbing themselves of the economic benefits to be derived from a more robust practice.

Since I wrote the letter just quoted we have been using the newer procaine solutions with cobefrin and, while several hundred injections have been made, we have yet to find one patient who had any unpleasant reactions.

The incorporation of cobefrin has made the procedure even more acceptable to the patient. My only objection to it is that it provides only a very short anesthesia in most instances. Undoubtedly, further research will soon permit a wider range of anesthesia time with cobefrin solutions.

The armamentarium for procaine usage is simple and inexpensive. Today, the technique is standardized, and the dentist can, with diligence, soon acquire a smooth technique. Its low cost and the fact that trained assistance is unnecessary in its administration, its comparative safety, and the rarity of serious complications, should render it universally popular. True, painless dentistry is now brought within the reach of every dentist and he has a moral and professional obligation to acquire the technique; it will pay big dividends.

702 Main Street
Willimantic, Connecticut

Health Insurance?

SO WHAT?

By HERBERT E. PHILLIPS, D.D.S.

THE Michigan State Medical Society recently voted to experiment with sickness insurance for Michigan's industrial workers. While the committee were formulating plans[1] a hue and cry was raised by some members who stated that health insurance was a failure in Europe and asked, "Why try it here?"

The objectors quoted statements made by the British correspondent of the *Journal of the American Medical Association* whose weekly reports, generally of an adverse nature, have been the main source of information to the general profession on the subject of English health insurance. The objectors also quoted from the digest of a speech by Sir Henry Brackenbury, former Chairman of the Council of the British Medical Association, printed in the Bulletin of the American Medical Association,[2] in which, by comments and italicizing, it was made to appear that Sir Henry was opposed to health insurance. Faced with these objections the Economics Committee of the Michigan Society, desiring to square their plans with facts, halted their work long enough to send two investigators, Doctors Nathan Sinai and H. A. Luce to England to find out, among other things, what the officials of the British Medical Association really think about the British health insurance scheme, and to determine if the British correspondent's statements actually represented the British professional point of view.

Sinai and Luce discovered that the British correspondent, though a physician and charged with the important task of interpreting the professional opinion in England for the American Medical Association, was not himself a member of organized medicine. In addition, and contrary to the impressions made by the correspondent's weekly comments, they found that the rank and file as well as the officials, instead of being opposed to, were

[1]Mutual Health Service, Supplement to J. Mich. State Med Soc. Vol. **33**, May, 1934.

[2]Editorial, What is Wrong With National Health Insurance? A. M. A. Bull. **28**:121 (November) 1933.

heartily in favor of health insurance, and were strongly advocating its extension to a larger proportion of the public. They reported to the Michigan Society that "the correspondent's comments created an erroneous impression and did not represent the opinions or views of the English profession."[3]

Michigan's representatives also interviewed Sir Henry Brackenbury in regard to his article in the *Bulletin of the American Medical Association* and received the following statement from him: "The interpolated comments in the '*Bulletin*' report are sententious and I think unfair and misleading because they imply or assume that possible strictures with regard to sickness insurance for cash payments 'apply also equally to medical benefit.' This is not so nor is there any justification for reading this into the address. Even in the report itself there is one instance in which the use of italics amounts to deliberate misrepresentation. In quoting alternative suggestions for dealing with certain positions one alternative is italicized, whereas in the address I immediately go on to declare that it is the other (non-italicized) alternative which should be adopted. This is an unworthy trick."[4]

In regard to the financial structure of the British insurance scheme it was found that the insurance societies had a huge cash reserve amounting to approximately $548,300,000. Last year, through a joint agreement with the physicians, there had been a cut of 10 per cent in fees for medical service.

In the health insurance report of the Committee on the Study of Dental Practice[5] it was estimated that physicians averaged about $2,000 a year from their panel practice in addition to their income from private practice. A 10 per cent cut would bring the amount down to about an $1,800 a year average, which amount coming in regularly has served as a back log to a physician's income in England and no doubt has been a factor in determining the present favorable attitude of the profession toward the panel system.

DENTISTS DISSATISFIED

The American College of Dentists contributed in part to the expenses of Doctor Sinai's trip and secured a report on the attitudes of the British dentists. While the English physicians have been able to congratulate themselves on a steady income from insurance practice during the depression, the English dentists, according to the report,[6] have been very much dissatisfied. The major cause of their discontent flows from the fact that when the insurance law was written over twenty years ago dental care

[3]Footnote 1, p. 17.
[4]Footnote 1, p. 10.

[5]Simons, A. M. and Sinai, Nathan: The Way of Health Insurance, University of Chicago Press, 1932.
[6]Footnote 1, pp. 16-17.

In 1911, Lloyd George successfully advocated social insurance; in 1934, Franklin D. Roosevelt announces that his program includes social insurance.

was not provided for as a statutory benefit, but was only given as an "additional" benefit to persons who belong to an insurance organization having surplus funds. Thus if the British lodge of Odd Fellows or Stevedores union had extra funds over and above what they spent for medical care they could use the surplus to pay for dental care for their members. Dental income, therefore, has not been as stable as the physicians' income, because the amount of funds available for dental care (never sufficient even in normal times) has always fluctuated with economic conditions.

Of course surplus funds have shrunk considerably during the present depression, and as a result patients have had to go without needed oral service and dental incomes have suffered. The British Dental Association now insistently demands that dental care be made a statutory benefit on a par with medical care, in fact they have been making this demand with increasing intensity for a number of years. They insist that dental care is as necessary in health service as is medical care and that health service funds should be allocated equitably to both physicians and dentists. They now realize that, instead of fighting the insurance scheme in the beginning, they should have formulated plans for adequate dental care and have fought for their inclusion when the health insurance law was written. Had they done so thousands of pounds might have been spent in the intervening years for dental care and the health of the English people would have been that much improved.

British dentists have gone through an experience which should be studied and understood by American dentists, as the history of the curtailment of dental care in the British health insurance scheme is now being rewritten in the United States. This point will be discussed more fully later.

1911 AND 1934

Many statements in the Sinai-Luce report indicate that in certain respects the early history of both medical and dental professions in England is being repeated in the United States. Doctor Cox who was secretary of the British Medical Association in 1911 states: "In 1911 we were not prepared for health insurance in England. If the professions had been first in the field there would have been saved much bitter feeling and loss of prestige. Up to the last minute the professions reiterated their statement against participation in any scheme of health insurance. At a meeting in November, 1911, the feeling against health insusrance ran high—Within a little more than a month the action taken against any participation in health insurance was rescinded."[7]

The repetition of the professional attitude in England in

[7]Footnote 1, p. 13.

1911, now being exhibited in the United States, is illustrated by the following incidents:

On Sunday June 10, 1934, in Chicago a Committee of the American College of Surgeons presented to the Regents of the College an outline of principles to be observed in insurance or group payment plans for hospital or medical care. They recommended that experiments along this line should be attempted by professional bodies. The outline with recommendations was endorsed by the Regents and given to the press. Wide publicity resulted and almost instant reaction came when the House of Delegates of the American Medical Association then in session at Cleveland took cognizance of the action of the College and referred to the Judicial Council a resolution presented by Doctor C. J. Whalen of Chicago condemning the College. The Judicial Council brought in a report, which pointed out, among other things, "that the American Medical Association was the policy forming body for the profession—that the College had given no consideration to policies or procedures adopted by the American Medical Association, that the actions of the College were harmful to the professions, and would give aid and assistance to those bodies and persons attempting to revolutionize medical practice. They recommended that the House of Delegates express its condemnation of such tactics and of this apparent attempt of the Board of Regents of the American College of Surgeons to dominate and control the nature of medical practice."[8]

The *policies* of the American Medical Association referred to in the foregoing passage are revealed in the "Report of a Special Committee" to the same session of the House of Delegates June 12, 1934: "On every occasion on which the House of Delegates has officially considered the question of compulsory health insurance and social insurance. . . .it has always condemned any system whereby the state would enter in any way into the practice of Medicine. In 1920. . .the House of Delegates adopted a resolution strongly condemning all forms of compulsory health insurance. . .The action of the House of Delegates has not been rescinded. . . .Your board of trustees, your executives, and all the publications of this Association have done their utmost thus far to carry out the policies which you have established. . .It is no secret that. . . foreign nations have state systems of medical care and that an intensive campaign has been carried on in this country. . .to cause the American medical profession and the American people to accept a similar type of medical practice. In accordance with the mandate of this House of Delegates, all the facilities of the American Medical Association have been used to oppose this trend. . . .It is

[8]Proceedings of the Cleveland Session: Report of the Judicial Council, J. A. M. A. **102**:2195 (June 30) 1934.

also now well known that the President of the United States . . .has come forth for the principle of social insurance. . . ."[9]

This official statement of "policy" explains many things —as the British correspondent, the Brackenbury comments, the difficulties of the Michigan insurance plan, the censure of the American College of Surgeons, and the general opposition to trends even when promulgated by the President of the United States.

TREND OPPOSED

Organized dentistry has likewise, but not in such elaborate detail, opposed trends toward health insurance and the following incident indicates the official attitude of the American Dental Association.

At the September, 1932, meeting of the American Dental Association, held at Buffalo, the House of Delegates appointed a Committee on Dental Survey which, according to its sponsors "would develop a program to combat the tendency to so-called State or panel dentistry, that would checkmate or offset the potential threats that confront the profession of dentistry." The delegates received hearty editorial support for this committee from the *Journal of the American Dental Association*[10] and from the then President of the Association who spoke of the timeliness of the work of the Committee on Dental Survey "when it is so evident that a plan should be developed and actions begun at once to combat the establishing of group practice and group pay through the medium of taxation and compulsory health insurance."[11]

While the professions in the United States are emulating their English confrères of 1911 in their opposition to health insurance we find American statesmen today emulating their British colleagues of the same early vintage.

In 1911 it was Lloyd George, the popular liberal politician, who successfully advocated social insurance as a means of improving the conditions of the workers in Great Britain, and history again seems likely to repeat itself as the administration at Washington in 1934 seeks popular support for its program of security for the American working class. Franklin D. Roosevelt, the popular Democratic President, announced recently that social insurance is now included in his program. Lloyd George as a politician and statesman was eminently successful. In fact, most statesmen who have advocated social insurance have been successful as candidates for political office, especially at times of unrest among the working classes.

Recalling the "about face" of the professions in England

[9]Footnote 8, p. 2200.

[10]Report of a Fact-Finding Committee of the American Dental Association and the U. S. Public Health Service, J. A. D. A. **20**:716 (April) 1933.

[11]Dittmar, G. W.: A Résumé of the Development of Organized Dentistry in America and the Present Status of the American Dental Association, J. A. D. A. **20**:1436 (August) 1933.

when faced with reality, and having fresh in our minds the nationwide professional acceptance of State medicine and dentistry under the FERA, we suggest to President Roosevelt that he need not take the negative attitude of the American Medical Association nor the American Dental Association too seriously when contemplating health insurance for the United States.

We call the President's attention to the splendid assistance given Mr. Harry Hopkins by officials of the American Medical Association in preparing FERA Circular No. 7 containing rules and procedure governing health service to between fifteen and twenty million persons on relief.

Doctor Patterson of the British Ministry of Health says, "The Ministry of Health consults the British Medical Association before taking any action relative to Medical Service."

The American professions are at least as intelligent as their English confréres, and there is reason to believe that, if the President were to call on the professions to assume responsibility for the designing of a nation-wide health service, the dead hand of an outworn policy would be disregarded, and they would quickly give whole-hearted response to his request.

A.D.A. CONVENTION

At the American Dental Association meeting[12] in St. Paul the outstanding and most talked of event was the speech by Doctor F. C. Warnshuis, speaker of the House of Delegates of the American Medical Association. President Wherry introduced him as "the one outstanding authority on Medical Economics who was in a position at this time to give sound advice to the American Dental Association."

Doctor Warnshuis has for fourteen years been one of the official family of the American Medical Association and in the past has been among the most orthodox in upholding the official attitude of opposition to the idea of group payment or health insurance. At the St. Paul meeting, however, instead of opposing these new methods of payment for health service he insisted that social trends are in that direction. He applauded the survey of medical needs and the health insurance plan published by the Michigan State Medical Society and used this survey and plan to illustrate what the professions in other places should do to meet present trends. He strongly

[12]This paper was written previous to the meeting of the American Dental Association in St. Paul, August 6-10. These comments on the speech by Doctor F. C. Warnshuis and the adoption of the Ten Principles to govern health insurance have been inserted in the original manuscript by the author.

recommended preparedness and leadership on the part of the national associations and advised united medical and dental participation in the building of a program of professionally controlled health insurance to provide medical and dental care to the low income groups.

Doctor Warnshuis, in presenting these ideas, spread consternation among our stand pat, reactionary politicians who are bending every effort to maintain the attitude of "combat" and "resistance to change" as the official policy of the American Dental Association. Their future political control is bound up in maintaining a fog of ignorance in the minds of the members, and one could almost see them tremble when Doctor Warnshuis illuminated the question at issue by the brilliance of his logic. He said, "there is one thing stronger than armies, *an idea whose time has come.* The idea of the necessity for some provision of adequate medical and dental care for the lower income bracketed groups is here. Shall we not embrace it and assume leadership that will place us in an impregnable position with a militant supporting force? To the timid and hesitant everything is impossible because it seems so. We dare not be timid."[13]

Doctor Warnshuis is the first member of the official family of the American Medical Association to break with the old orthodoxy and "hit the trail" as a modern pragmatic advocate of "an idea whose time has come." There is no doubt but that the facts disclosed by the Michigan State Medical Society of which Doctor Warnshuis was Secretary were a major factor in destroying for him the validity of the American Medical Association policy. At any rate Doctor Warnshuis' experience in Michigan developed him into "an outstanding authority on Medical Economics" and prepared him to answer the call from California to "Come out and help us." He is now on his way to take up his new position of Executive Secretary of the California State Medical Society whose officers and members are face to face with proposed legislative action on compulsory health insurance. Judging by his words in St. Paul Doctor Warnshuis will not be timid but will boldly advocate the development of *professional plans* for health insurance that will place the profession in California in "an impregnable position" of community leadership in health service.

A second event[12] of importance at St. Paul was the adoption by the House of Delegates of ten principles that should govern any new method of health service payment. In this the American Dental Association has followed the lead of the American Medical Association whose House of Delegates took similar action[9] last June at Cleveland.

Both organizations by presenting principles which must govern the administration of health insurance to which they

are opposed, must, if the principles are to be put into effect, abandon the position of opposition and become participators in planning health insurance schemes, or they must abandon the principles and let lay groups organize the program. Doctor Warnshuis advised the first of these alternatives.

It is interesting to note that both organizations followed closely the conclusions arrived at by the Committee on The Study of Dental Practice, following their investigation of compulsory health insurance in Europe, and endorsed an elaboration of the principles formulated in their report.[5] Mr. A. M. Simons who with Doctor Nathan Sinai made the European Study for the Committee on the Study of Dental Practice has been, since finishing the work for the dental committee, the economist for the Bureau of Economics of the American Medical Association, and it was in this bureau the ten principles were outlined for presentation to the delegates. American Dentistry can take pride in the fact that the most authentic study yet published on the subject of professional relations under European health insurance, was carried out under dental auspices with funds furnished by the American College of Dentists. Medical and dental societies now making studies of social trends find this report of inestimable value.

We turn again to the pages of history written in England in 1911 to find material of fundamental importance to the dental professions. Dental care was not included when the insurance laws were framed in England because of cost, and because of lack of appreciation of the value of dental care by Lloyd George and his advisers. An infinitely wider understanding and recognition of the health menace of oral pathology now exists, and it is unthinkable that any who come within that wider circle would for one moment question the imperative need for including *adequate dental care in any new method of payment* regardless of cost.

Despite this imperative health need medical societies, governments, and lay organizations show a tendency to ignore dental care as an integral part of their insurance programs. The California State Medical Society and the Milwaukee County Medical Society gave scant attention to dental care in their voluntary insurance plans, and the Michigan State Medical Society did not ask for dental cooperation until their medical plans were completed. Medical society officials have been frank in their recognition of the fact that the inclusion of dental care would make health insurance cost more, so let us start, they suggest, with medical care alone; dental care can come later.

(To be concluded next month)

[5]St. Paul Pioneer Press, August 8, 1934.

5427 S. Ashland Avenue
Chicago, Illinois

DENTISTRY

Rescued or Deserted

By JAMES RALPH ZION, B.S., D.D.S.

THE depression that has been gripping the world painfully in recent years is not a mysterious stranger in the history of civilization. The present state of our affairs may be viewed simply as a climax and culmination of a multitude of man-made errors, poorly conceived ideas founded on ignorance, greed, selfishness, and other impediments to civilization's progress. As soon as these ideas, or enough of them to release the negative pull, are discarded and thrown overboard then, and only then, will the march of civilization resume motion toward truth and progress.

The profession of dentistry need by no means be an "innocent victim" of the avalanche of human mistakes. Every dentist should strive individually to make certain that his profession offers a "clean bearing" on which the machine of civilization may move forward, and not continue as one of the burdens held over stubbornly for future recognition and discard.

Too many dental societies are controlled and officered by dental college teachers, or dentists on some tax money pay roll, for the purpose of preventing the great body of dental practitioners from rising up in revolt and demanding the closing of many dental schools and elimination of free government dental service. Many insincere pseudo-leaders, waving a stolen banner of altruism, are trampling and snuffing out a livelihood for the multitude of dentists.

Dental schools paint a beautiful picture for the uninformed and prospective student and his parents; but, in reality, the school is frequently after the tuition and revenue from clinic patients. The picture captioned "not one-tenth enough dentists to do all the dental work needed *if* people ever decided to have it done" has kept our dental schools going, and not until the investment of money is "too great to turn back" does the dental student begin to see the true picture, and realize that if people ever began to have all the shoes, hats, clothes, homes, furniture, and so on, that they need, there would not be one-tenth enough cobblers, hatters, tailors, carpenters, and cabinet-

"Dental schools paint a beautiful picture for the uninformed and prospective student and his parents."

makers to supply them. The old story about the "better mousetrap" and "better sermon" has filled our office buildings with unemployed dentists.

Manufacturers of dental equipment testify, and we know (to our sorrow) that the making of a dentist costs "our social order" well over $10,000 —an investment not easily deserted—which is the reason more men, or their supporters, don't leave dentistry. Dental schools are now simply a source of wasteful overproduction for use by the thoughtless public and advertising dentist in chiseling ethical practice. Attention is called to the fact that, out of a recent graduating class of dentists, less than a third of their number attempted to open offices for the practice of ethical dentistry.

Dentists on public health or welfare boards or in clinics are after votes for officials who hand out jobs in dental clinics supported extravagantly and wastefully by tax money; some have even been able to scheme around through "civil service" and win "life appointments" to draw upon the taxpayers' money.

No, the school and government dentists' interests offer no help to the man who must practice dentistry privately and for a living; and when this is challenged or seems contradicted, examination will reveal the true motive well disguised and carefully hidden by subterfuge. The real interests of each are as far apart as night and day.

The ethical dentist, using all his effort struggling with a private practice as his only means of existence, finds himself bewildered and alone combating, first, scrambled governmental methods of free dental service; second, not only competitive prices of dental school clinics, but competition caused by the yearly unloading—from a horde of schools—of thousands of green, inexperienced dentists on the back of our dis-

tressed profession, and on our citizens. "Reproduction" in the last ten years has been so fast that the struggle for existence has forced so many dentists into quackery and fake practices that the public at large candidly admits being in a quandary relative to all dentistry. The casualities of recently attempted practices are far too overwhelming to permit us to give further credence to the schools' accusing finger pointed to the "fault of the individual." Where the public has "bitten" sufficiently on unethical practices to make a "clean up," some of our wise dental economists hold it up to our view under the label of "personality" and send its praises through the land.

"Thanks for the American Dental Association," someone says. "Yes? For What? $15 a year?" Misrepresentation of the boldest kind is allowed to run rampant; newspapers, magazines, radios, or "street speelers" advertising dentistry or dental products have become so bold that the crudest methods are used to attract attention. False claims are made and recognized as ridicule and contempt directed at ethical dentistry, not only by dentists, but the public at large senses the condition and believes that so long as the "dentists" permit such advertising it naturally is the *truth*. In many fields of industry, codes of the NRA discipline unfair practices less culpable, but the American Dental Association, under the spell of the few leaders who dictate the action or rather lack of action, ordains that "there shall be no dental code."

There are 70,000 dentists in the country, and dentistry is in the "wreck" with everything else, through depression. Leaders of other fields of human endeavor, through codes, are forming "wrecking crews" for checking further destruction, separating the good from the bad and for building the New Deal on a strong foundation. The A. D. A. recognizes *no wreck* and evidently sees nothing to "salvage." Let every dentist answer this: *Is our profession a total wreck, completely lost with nothing worth saving? Or, were we so free from the wreck that we don't need even a slight repair crew?*

If dentistry "as a livelihood" is to be saved and march along to progress with other branches of human endeavor, there is no more time to be lost idling; quick action now is necessary if we are to join "The Column Of Those Rescued From The Depression." The few politicians who call themselves "organized dentistry" are turning us back with the command: "There will be *no code;* nothing will be done in dentistry, Amen!" Well, if that be the case, we as a profession have learned nothing from the depression; no progress has been made; "adrift" we are left upon the "black sea" of misunderstanding and disappointment.

A complete change in state and national officers in the A. D. A. is not only vital, but prerequisite to measures of any real consequence. The start *must* be made *locally*. Impeach disloyal and "do-nothing" officers of local societies and select men who practice dentistry for a living; they constitute 95 per cent of us; they know how and will lead the way to the New Deal. Support them to a man.

Many of you will recall our President's story about "Old Hickory" Jackson going to Heaven if he wanted to "bad enough"; so it is with us: we can improve conditions in dentistry—"if we want to bad enough"—if we have the will to do it.

450 Sutter Street
San Francisco, California

MINNESOTA HYGIENISTS WIN CUP

The ORAL HYGIENE Cup was won by the Minnesota Dental Hygienists' Association at the recent A.D.A. convention in St. Paul. The cup was awarded this year to the State Association that had the greatest number of paid members in attendance at the convention. In previous years the cup was awarded to the State Association whose members traveled the most miles to attend the A.D.A. convention.

"I do not agree with anything you say, but I will fight to the death for your right to say it."

—*Voltaire*

IN DEFENSE OF DENTISTS

Presumably, I should be gathering myself up from the dust of the gutter, thoroughly begrimed and bruised, with a proboscis battered and bloody and a spirit discouraged and forlorn. For I have just read Frank Dunn's[1] article "Owls or Cuckoos."

The opposite, however, is true. A feeling of extreme pity creeps over me when I contemplate that our profession too has its quota of pedants. I know of no cruder form of erudition than to flaunt the possession of a bit of knowledge in the face of your brother man and assume that you have placed yourself on the lofty pinnacle of consummate learning and sneer at those of your associates who are apparently the epitome of crudeness and vulgarity.

Dean Miner should know, and that holds for Dunn too, that the possession of an A.B. degree is no guarantee of a man's intelligence or superior mental capacity. I have mingled with many A.B.'s, and in Boston they abound, and to my recollection I have never heard them quote Sophocles or Socrates, nor have they resorted to the comedies of Aristophanes for their humor, and, if my memory serves me correctly, I believe that they have been guilty of using an occasional split infinitive.

Traveling is broadening, and I regret to say that to date I have been more or less confined to the environs of New England, but at the first opportunity I shall positively visit Cleveland and observe a section of this country where men are men and dentists have bad table manners. And, I am sure, that should I observe an itinerant citizen with high forehead and beetled brow, absorbed in contemplation with disdainful visage, I shall without hesitation go up to him and say, "Doctor Dunn, I presume."

How can anyone ignore the fact that while "ordinary clerks" are doing their routine duties day in and day out, the prospective dentist is acquiring knowledge in anatomy, physiology, biology, chemistry, and other kindred subjects? Is this knowledge to be sneered at? Is this period of education to be considered stagnant and unproductive? We may not go out of our way to look up Haji Abdu El-Yezdi or other obscure Persian poets whose names are more musical than their poetry, but who can say that he who has knowledge of the classics and is ignorant of the sciences is more

[1]Dunn, F. A.: Owls or Cuckoos, ORAL HYGIENE **24**:989 (July) 1934.

learned than one who has knowledge of the sciences but only a passing acquaintance with the classics?

Let Doctor Dunn refer to the May issue of *Vanity Fair*.[2] Let him contemplate the shocking lapse in table and street manners of some of the leading celebrities here and abroad and, perhaps then, he will hold a little sympathy for his brother dentist who daily renders a symphonic soup swizzling.

Perhaps in Doctor Dunn's circle of college graduates they all pronounce the words: grimace, debacle, garage, automobile, ague, sacrilegious, aerial, and other such common words; but let any dentist make it a habit to pronounce Tuesday correctly, and many a patient will raise a quizzical eyebrow and fear that his doctor has gone slightly "ritzy."

The dental profession as a whole need offer no apology for its general knowledge and deportment. It compares favorably with that of any of the other professions, and, if its conversation is almost wholly limited to discussion of dental subjects, it is true only when dentists get together, an axiom which holds true as well when shoe manufacturers gather, interior decorators convene, retail merchants assemble, or representatives of any selected trade, business, or profession meet for common discussion. Only when these groups are mixed does the conversation veer toward matters of general economic, sociological, and diverse problems.—ABRAHAM GURVITZ, D.M.D., 125 *Tremont Street, Boston, Massachusetts.*

●

ADVERTISING VS. ETHICS

The charlatan in any business sells his wares with the prime object of mulcting a public who, unsuspecting, is being deceived. The great average of dentists today will not, and cannot, deceive their patients, and "get away with it."

If we must compare, let us compare dentistry with the nation's biggest industries. Do those industries sit back and wait for buyers of their products to come to them? Do they (or we) consider it unethical that wherever we go we are reminded that Packard wants you to "ask the man who owns one," and Luckies are made from the "Cream of the Crop"? We know, for instance, that Florida Board of Trade spends money for ads inviting you to partake of the "Florida sunshine," and Flit "knocks 'em dead." And, when we buy, we want the known brands. Known, because in our daily travels we are constantly reminded, constantly prodded, constantly made conscious of "that school-girl complexion" and "B.O."

Now let's get back to the dentist and that beautiful office of his waiting for the day when the SRO sign must be hung out. Maybe he doesn't use Lifebuoy soap, or Listerine. Maybe he does not shave with that "Velvety feeling."

The true facts however, are these. We are going through a period of civilized socialization involving many radical changes, which necessarily alter our perceptive habits. Today we realize for the first time in our daily lives the truth of Aesop's motto, "it's a wise man who knows he's a fool." But *do* we realize? Have we changed? After all these years we suddenly come to the realization that our *ethics* and "front" are being destroyed by charlatans who advertised in a big way. Were the advertisers prosperous? Of course they were. And not only that, they were attracting the attention of patients who were seeking the light. Didn't they find out then that the so-called ethical ones were mulcting them without advertising that fact? Which was worse? Who was right? Who got the dirty deal? And then what happened? A few moguls decided that it was about time that Park Avenue moved over to Third Avenue. Why let the public know anything? Keep them totally in the dark. *Down* with the signs, *all* signs, *down* with advertising, *all* advertising. And with what result: they're *all* starving to death.

[2]Hey, You—Mind Your Manners! Vanity Fair **42**:23 (May) 1934.

Just what *is* advertising? What does it do? Advertising merely makes the general public "conscious," registers on their minds, educates them, *reminds* them. Would it be asking too much to make the public "Dental Conscious"? How can we do it ethically? The dental societies, who are ever-mindful of the welfare of the dentist, together with dental manufacturers, should foster series of advertisements in the press of the country designed to make the public read every day, see wherever they go, big attractive articles and posters on the value of dentistry, benefits to public health and so on. Press agents and advertising agents telling the public the truth about dentistry; telling the truth about clinics, *who* they are for, what they do, and what the private practitioner *does*; telling the truth about dentists devoting their services to those who are destitute, those who are deserving; showing what dentists *can do*.

And just another point while we are at it. Let's give our young graduates a real opportunity to learn a little more than everything they already know! Apprenticeships! Why not require a dental school graduate, by law, to serve under and with a practicing dentist, of at least ten years experience, for one year? Maybe they'd *both* learn something.

And for once in our professional lives, let's take the *initiative* in matters pertaining to dentistry. Forget to emulate physicians. Let them solve their own worries in their own way! Let's show them something to follow. Too long have we patterned ourselves after the medical fraternity, and *they*, in turn, have been more or less in the morass of darkness for lo, these many years. Let us lead, not follow.

Throw away your red ink. Polish up your office and *smile* because one of these fine days, after you interest yourself enough to actively engage in battle, you'll find some panaceas as these. Remember it's a wise man who *knows* he's a fool." —NEWMAN D. WINKLER, D.D.S., 2488 *Grand Concourse, New York City*.

●

THE COLLECTION RACKET

If any further proof were needed that ORAL HYGIENE is read by dentists, it was supplied, yesterday, to me by a representative of a collection agency, who has been employed about three weeks by a company that uses a type of contract described in the August issue.[3] He told me that when he started to make his rounds among the dentists in ———— yesterday, the only thing he encountered was a series of firm refusals to even talk about collection agencies. This man said that he could not obtain a single interview with any dentist he called on. I explained the contract to him and, after he saw the light, he said he was going to quit his job and attempt to secure the cancellation of the contracts he had obtained, because eight of them had been obtained from personal friends. He was rather sad when he left the office.—FRANK W. BROCK, New York *Better Business Bureau*, 280 *Broadway, New York City*.

[3]Brock, F. W.: The Collection Racket Exposed, ORAL HYGIENE **24**:1138 (August) 1934.

Writers are requested to confine themselves to 150 to 200 words, when writing for the DEAR ORAL HYGIENE Department.

W. Linford Smith
Founder

ORAL HYGIENE

EDWARD J. RYAN, B.S., D.D.S.
Editor

Editorial Office: 708 Church Street, Evanston, Illinois

Give me the liberty to know, to utter, and to argue freely according to my conscience, above all liberties. — *John Milton*

MUST DENTAL MEETINGS BE DEADLY DULL?

A DENTAL convention is typically a combination of scientific questing, political mugwumping, revelry, irregular hours and uneven meals. A convention is plenty of fun, and profitable while it lasts, but after the fourth day most conventioners are ready to turn their haggard faces homeward. At home, the post-convention period is often characterized by varying degrees of headache, experimentation in new techniques and methods—some that were learned from the official clinicians on the programs, and others over the tall glasses in informal discussion in somebody's room. I have heard colleagues remark that they learned more in the personal and intimate debate on the golf courses, in night clubs, and in the hotel lobbies and rooms than they learned from the serious, scholarly, and frequently self-conscious essays of the programs.

The essayists on the programs are usually good clinicians and practical fellows. When they write a paper, however, often all spontaneity is submerged; they array their subjects in the esoteric jargon of the physicist, and deliver their essays with the solemnity of an executioner.

This malady may be known as *rhetorical and rostrum illness;* it is always fatal to the attention the essayist receives; it is always characterized by the classic symptoms of boredom in the audience and later the clinical picture of stuporous sleep. Trap these essayists in a tap-room and get them talking on their pet subjects—with appropriate gestures and invective—and their discussion is picturesque, practical, and understandable. Why do they cease to be natural in delivering an essay?

None would suggest that dental meetings be transferred from the level of the funeral eulogy to the debased level of the tavern, although the Greek philosophers did a pretty good job of teaching under the trees in the groves about Athens. Socrates and Plato, for example, sprawled out on the ground in fine informality or reclined at banquet tables in their give and take method of teaching their pupils; they did not need rostrums, swallow tail coats, and amplyifying systems.

Essays on scientific subjects, however, can be prepared and delivered with individuality, some humor, and dash without degrading the subject. Three popular clinicians come to mind who combine factual and practical material with *savoir faire* of presentation; Howard Raper, Clarence Simpson, and Dayton Dunbar Campbell. Any meeting that one of these men appears before is well attended because the listener is assured of information presented in a way that he can understand and make use of in his everyday practice without exerting a strain on him in the process of acquiring that information.

Another cause for the painful dullness of some dental meetings is the needless reference to the musty archives that some essayists consider necessary to make their presentations complete. Why, for instance, in a paper on the gold inlay it is necessary to go back and mull over the metal work of the Phoenicians, or in a paper on dental caries it is necessary to take a Burton Holmes travelogue around the world, is a situation that has often distressed

me. We do not object to a bit of archeology or geography now and then, but would rather have it in straight doses and not mixed up with dental subjects. I dread the day when some enterprising clinician gets the idea of dragging a dinosaur skeleton into the meeting room to prove his theory of malocclusion.

Meetings should start promptly and a stop-watch should be held on the essayist to be certain that he says something about his subject in the first three minutes of his speech. If his preamble is too long, too loaded with tributes to the gracious ladies, the climatic conditions, or hoary jokes he should be gaveled out of order. The essayist should be allowed sufficient time to present his subject: ten minutes is too long for some subjects and two hours is not long enough for others. In a democratic assembly the suffering audience should be allowed to determine how long an essayist should speak. If he is going strong and pouring out the information, there will be few yawns, little aside whispering, and the chairs will seem to be comfortable. Gaping, a rising hum of whispering, and nervous cheeks are among the signs to the essayist that he is wearing thin his welcome.

If program chairmen selected essayists for their professional erudition plus stagecraft; if they insisted that essayists stayed somewhere within the subject; if meetings began promptly and ended before everyone was exhausted; if chairs were comfortable, and the ventilation good—then meetings would be, in the words of Frank Dunn, "easier to bear."

FOIL CARRIER *and* DENTIST

By REA PROCTOR MCGEE, D.D.S., M.D.

MAKING a living these days can be mighty interesting if you happen to have a hobby that is necessary to the movies.

Doctor Wilfred J. Holroyd, formerly of Pittsburgh but for some years a dental practitioner of Los Angeles, is the champion fencer of the Pacific Coast. On the screen it is sometimes necessary to show a duel with rapiers. There are some actors who can put up a pretty good contest with protected fencing foils and further armored with wire fencing masks and body pads; but when it comes to a rapier duel with sharp points and no face or body protection whatever, both contestants must be men of the most uncanny skill if the picture is to be convincing and if both duelists are not to visit the hospital or the cemetery. This is where Doctor Holroyd shines.

A picture produced by Metro-Golden-Mayer, starring Greta Garbo supported by John Gilbert and Ian Kieth, is called "Queen Christina." In the great fencing scene, Doctor Holroyd doubles for Ian Kieth in the character of "Magnus." Dressed in the costume of the late seventeenth century, he makes a splendid appearance and, when he goes into action against a professional swordsman who is doubling for John Gilbert, it makes you think of the wise crack about "slicing 'em thin."

Doctor Wilfred J. Holroyd

The scene is laid in the big pines up above Lake Arrowhead, about fifty miles from Los Angeles. In order to make this fight scene the duel had to be fought eight times. Some of the most peculiar things hap-

pen, to spoil difficult scenes. In this case the camera ran off the track once and at another time the "Princess" was riding through the scene mounted on a gorgeous horse, with a very long and impressive mane and tail. Like much of the hair in Hollywood, the mane and tail were mostly artificial. Right in the middle of the scene the horse decided to try switching that new tail and off it came. Could you blame them for taking the scene over again?

Doctor Holroyd says that whoever told him movies were easy work was mistaken, but that the interesting people, the wonderful location, the picturesque sets, and the ancient costumes were happy additions to his memory.

Hollywood Security Building
6381 Hollywood Boulevard
Los Angeles, California

Dental Meeting Dates

The Odontological Society of Western Pennsylvania, 53rd annual meeting, William Penn Hotel, Pittsburgh, November 7-9.

The Massachusetts Board of Dental Examiners will hold an examination for registration of dentists and hygienists in the City of Boston, on November 19, 20, and 21. Full information may be obtained by applying to W. Henry Grant, D.M.D., Secretary, Room 141, State House, Boston. All applications must be filed at the office of the Secretary at least ten days before date set for examination.

Board of Dental Examiners of California, next regular meeting. San Francisco, December 3. Applications must be in the hands of the Secretary at least 20 days prior to the date of the examination. Address all communications to Doctor K. I. Nesbitt, 450 McAllister Street, San Francisco.

New York Dental Centennial, Hotel Pennsylvania, New York City, December 3-7.

Midwinter Meeting of the Chicago Dental Society, Stevens Hotel, February 18-21, 1935.

Looking for Trouble

By W. J. Furie, D.D.S.

WHY do dentists go out of their way looking for trouble? I refer to those who follow the advice of articles that urge dentists to handle their own orthodontia cases.

I cannot too strongly advise you against this; it is taking patients' money under false pretenses. In the long run you lose the patients as well as your reputation, and you may do an irreparable damage.

After thirteen years in the exclusive practice of orthodontia, I earnestly believe that every orthodontist should spend two years as an interne does, in order that the public will not suffer from his lack of training.

Every young orthodontist acquires many grey hairs his first five years in practice, and, after that, he worries more than ever, because he begins to realize the seriousness of his problems, and he knows that, in many cases, he can give little relief as they represent conditions over which he has no control.

The orthodontist encounters not only his own problem, but occasionally some dentist brings in a person he has been treating for several years, and swears that if you will help him out, he will never touch another case of orthodontia.

I have had such experiences myself. A case in point is this: A dentist, who is a friend of mine, presented a patient and said that he was afraid to remove the appliances or take an impression, and that, if the wind blew hard when the patient's mouth was open, she would lose several teeth. I immediately advised extraction of four devitalized lower incisors, and placed an upper retaining appliance that she will have to wear the rest of her life. Yet he thought it was a simple case.

From San Pedro I have a report of a more recent case. The dentist wanted to help the patient, who did not have much money. The girl is now twenty-two years of age and, after several years of treatment, she came to my office to see if I could complete the work for her. She had a maxillary protraction with a deceptive bite, so that, when she closed her teeth for examination, she would protrude the lower jaw until the teeth rested comfortably, and it didn't look bad. The dentist had placed the upper appliance only, and widened the upper arch until the occlusion was fair, with this protrusive bite. During mastication or normal bite, the lingual surface of the upper posterior teeth occluded buccal to buccal

surface of lower posterior teeth, with devitalization of four upper anterior teeth, and the posterior teeth were hopelessly loosened.

I used the necessary precaution and explained to her that I could do nothing for her. She returned with an attorney, and he wanted to sue her dentist for $30,000 and was sure my testimony would win the case. He pleaded with me, saying the orthodontists should make an example of dentists doing orthodontia. Of course I refused to testify and so did every other orthodontist, so the case was dropped.

This dentist was trying to help a poor girl, and the poor girl tried to ruin him.

Similarly, another law suit was averted. A dentist told the parents of a girl aged 11 that her teeth would straighten out without treatment. When she was 14, he pulled the upper cuspid to help straighten them. Four years later she came to me. She appeared to be beautiful until she opened her mouth. Naturally she was angry with her dentist and wanted to sue him for damages for not advising her correctly. The suit was stopped, but her tongue was not, and she did that man an unbelievable amount of damage. Every orthodontist is called on frequently in such situations to protect a dentist who has ruined some child's mouth and health.

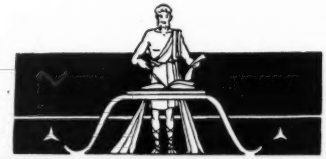
The dentist who publishes articles advising his fellow practitioners to start on a few orthodontia cases without any special training should be held liable for the damage he may do. Encourage a man like that and his next advice may be to dentists, "Take out all infected tonsils, why send the patients to a specialist?" I would rather have a dentist who is a general practitioner remove my child's tonsils than straighten her teeth.

The public deserves our protection and the very best service we can give. We should not besmirch our profession by failures with which the public has no patience.

1113 Security Building
Long Beach, California

NEW YORK DENTAL CENTENNIAL

The New York Dental Centennial meeting to celebrate the hundredth anniversary of the founding of the first dental society, The Society of Surgeon Dentists of the City and State of New York, will be held at the Hotel Pennsylvania, New York City, December 3-7, inclusive.



Ask ORAL HYGIENE

Please communicate directly with the Department Editors, V. CLYDE SMEDLEY, D.D.S., and GEORGE R. WARNER, M.D., D.D.S., 1206 Republic Building, Denver, Colorado. Please enclose postage. Material of interest will be published.

LESIONS FOLLOWING EXTRACTIONS

Q.—I am affiliated with a school clinic in which there have been several cases of lip sores following tooth extractions. Two of the cases were my own, and another operator in the same clinic had several. I have never encountered them elsewhere, nor can anyone here advise me because they are entirely foreign to the rest of the operators.

The sores appear quickly on the lower lip after a procaine extraction, sometimes within a few hours or in one night. They appear on the mucous membrane as white spots, some small, some large, similar to burns. The lip swells up and does not heal for a week. The majority of these sores follow mandibular injections, I believe.

I have thought of several possibilities—first of an alcohol burn, as the syringe in the clinic is sterilized with alcohol, but I am always careful to rinse the syringe before using it. Or would procaine poisoning cause these sores?

Please give me your opinion as to what they are, how to prevent them, and how to treat them.—J. S., D.D.S., Pennsylvania.

A.—The sores that appear on the lips of patients after the injection of procaine are probably not a result of the procaine itself, but the result of a disturbance of the nerves. As you know, alcohol is not especially escharotic, and even if there should be alcohol left on the syringes it should not burn the lips enough to cause a sore. If these sores occur as a result of the use of procaine I cannot see why the condition should not be more or less general, but, as a matter of fact, this is the first time my attention has been called to any such thing. We frequently have sore lips, herpes facialis, as a result of extensive dental operations, but, as I said in the first place, this is a condition of the nerves or nerve nodes and is in no way related to the use of procaine.

We have in our organization a man who had a two-year fellowship at the Mayo Clinic, and he saw no such cases there, and naturally he saw a great many patients who were below par and in whom such results might be expected, if to be expected in anyone. I am inclined to believe then, as your letter would indicate, that this

is a local problem and that it calls for a very careful analysis of all the conditions surrounding the use of anesthetics and the extraction of the teeth in your particular clinic.—GEORGE R. WARNER

●

SPECIFIC FOR VINCENT'S ANGINA

Q.—Do you have any new specific for the treatment of Vincent's angina and what is your method of treatment?

Please advise also what suture you recommend using after extraction, whether the absorbent or nonabsorbent, and the kind of material.—J. R. B., D.D.S., Texas.

A.—So far as we know there is no specific for the treatment of Vincent's infection of the mouth. If there were it would seem peculiar, to say the least, that there have been fifty or more remedies suggested for the treatment of this condition.

If the case is chronic we use a 7 per cent solution of chromic acid followed by a 50 per cent solution of hydrogen dioxide, applied in the following manner: The gingival trench is isolated from the rest of the mouth with cotton rolls and then a droplet of the chromic acid is introduced to each interdental space from a doppel dish with cotton pliers. With another pair of pliers a drop of the hydrogen dioxide solution is put on the chromic acid. This will make the chromic acid turn black, and nascent oxygen will be released. After ten minutes more hydrogen dioxide is added, which usually completely neutralizes the chromic acid. This treatment is given daily until no organisms can be seen in a smear. At the same time prophylaxis treatments are given until the gums return to a normal tone.

Catgut No. 00 is most commonly used to suture wounds following extraction. This is absorbable. Some men use the nonabsorbable silk or horsehair.—GEORGE R. WARNER

●

SYPHILIS TREATMENT

Q.—I wish to know in what form mercury was formerly given by mouth for syphilis. I know of neosalvarsan and sulpharsphenamine being used hypodermically, but what I want to know is in what form mercury was previously used and the dosage. I would also like to know why the former practice was abandoned.—H. B. F., D.D.S., North Dakota.

A.—Mercury was formerly given by mouth for syphilis, in the form of massa hydrargyri, dose, grs. 1-10, hydrargyri chloridum mite; dose, grs. ½ to 15, or one of the iodides. These were considered specific, but they were not as specific or effective as when used with the arsenics, and, after the discovery of "606" by Ehrlich, the arsenics largely replaced all other medication in the treatment of syphilis. Neosalvarsan (neoarsphenamine) is simply an improved or new form of "606" and is used as a hypodermic so that its effect on the Spirochaeta pallida may be immediate and direct.

At the present time, both salvarsan and neosalvarsan are used, each having some ad-

vantage, but it has been found that mercury or/and bismuth should be used concurrently or alternately with the arsenics.

You will find an article on the subject in the *Journal of the American Medical Association*, entitled, Standard Treatment Procedure in Early Syphilis.[1]—GEORGE R. WARNER

●

EXCESSIVE SECRETION OF SALIVA

Q.—Please publish in the ASK ORAL HYGIENE department the method of diagnosis and treatment of a patient whose glands secrete such an excess of saliva that he almost chokes, especially at night. The teeth and mucous membrane of the mouth appear to be healthy. The patient's physician administered atropine which almost caused blindness, but the amount of saliva did not decrease.—A.M.W., D.D.S., Pennsylvania.

A.—Excessive secretion, ptyalism, salivation or sialorrhea, inability to swallow normal amount and excessive secretion may be confused. The first results from coma, (anesthesia), in facial or bulbar palsy, when the tongue and lips are involved, in tonsillar and peritonsillar swelling, retropharyngeal abscess, esophageal paralysis, diverticulum, and stenosis.

The true ptyalism occurs as a psychical reflex under the following conditions: sight or odor of food, joy, fright, worry, and anxiety are sometimes the causes. It is sometimes a prominent and early feature in a psychosis, as in general paralysis, melancholia, and dementia praecox. The sound of high, shrill, and disagreeable notes is occasionally a factor. It is a common symptom in hysteria. It has been found in organic nerve disturbances, for instance as the aura of an epileptic attack, in tabetic crises, in brain tumor, in hemiplegia, in trigeminal neuralgia, encephalitis, chorea, migraine, and paralysis agitans. It may be a manifestation of general diseases, much as pancreatic disease, gastric hyperacidity, intestinal parasites, otitis media, or hydrophobia. It is sometimes an indication of anaphylaxis. It occurs from the administration of certain drugs, such as mercury, iodine, or pilocarpine.

The treatment would depend on the cause. The foregoing is taken largely from Practice of Medicine by Frederick Tice.[2]—GEORGE R. WARNER

●

SOLVENT FOR SALIVA

In response to your request for an immediate solvent for the relief of ropy saliva, I would suggest that you try this: Inflate the lungs with a deep breath and then hold your breath for as long a period as possible with safety; then exhale. Do this several times: and you will note a release of more fluid and refreshing secretions from all the salivary glands.

[1]Stokes, J. H. et al: Standard Treatment Procedure in Early Syphilis, J.A.M.A. **102**:1267 (April 21) 1934.

[2]Tice, Frederick: Practice of Medicine. Vol. 12, Hagerstown, Md. W. F. Prior, Inc., 1917.

It is probably the action of carbon dioxide which increases during suspended respiration that makes body fluids more solvent.—O.S., D.D.S., New Jersey

●

CONDYLES SLIPPING

Q.—I have a patient, a young woman, 22, who has for the last six or eight months been troubled with condyles slipping out and frequent locking of the jaws, even when she is not having dental work done, or exerting her jaws in any way.

The condition is growing worse and, of course, the patient and her parents are alarmed. Could you suggest some treatment?—D.B.C., D.D.S., Alabama.

A.—This is a difficult problem, and I must confess that I do not know much about it, but I would suggest that you try fitting the upper and lower posterior teeth with orthodontic bands, carrying hooks to engage rubber bands that can be applied to exert sufficient tension, when the jaw is opened, to prevent its slipping out; or possibly it would be best, to avoid tooth elongation, to band every tooth in the mouth and attach them to labial arches to carry the restraining rubber bands.

The idea of this procedure would be to prevent the condyle from slipping out of the fossa for a long enough time to permit the ligaments and muscles to shorten and strengthen and at the same time to permit some exercise of the jaw muscles and normal use of the mouth.—V. C. SMEDLEY

●

HYPERSENSITIVE DENTINE

Q.—Will you please give me the names and addresses of two of the best known men on dental therapeutics in order that I may write them for their opinions on the continued use of an agent used by many members of our profession for the treatment of hypersensitive dentine (3 drams each of zinc chloride, tincture of iodine, and distilled water)? By "continued use" I mean the repeated application of this agent to all of the teeth two, three, or four times each week over a period of two, three, four, or five months.

I have been using this agent for about two years for the treatment of hypersensitive tooth necks and have in every case obtained gratifying results with it. I have also found it to be valuable in controlling hypersensitiveness after scaling in the treatment of periclasia, and it is in this connection that I seek safety in its "continued use."—H.W.S., D.D.S., South Carolina.

A.—Doctor Herman Prinz, 40th and Spruce Streets, Philadelphia, Pennsylvania, and Doctor John A. Marshall, University of California Dental Department, San Francisco, California, are recognized authorities on dental therapeutics.

Personally, I can see no reason for any harm from any number of applications of the formula you quote, unless possibly in case the dentine treated were in close proximity to a pulp.—V. C. SMEDLEY

CORRECTING PERLÈCHE

Q.—Would opening the bite help the condition of a patient who has perlèche? She is a woman aged 50, who has worn a denture for about twenty years.—C.H.E., D.D.S., Minnesota.

A.—True perlèche is supposed to affect children only. Is it possible that your patient's trouble is a chap caused by the oozing of saliva into wrinkles at the corner of the mouth? If so, the condition could no doubt be corrected or greatly helped by opening the bite, and adding some extra buccal contour to help support the sagging tissue.

You might test this idea out before making the new dentures by building the old ones up with modeling compound and adding either compound or wax for buccal contour. Let the patient wear them so for several days to see whether the condition improves.—V. C. SMEDLEY

●

AFTER EFFECTS OF EXTRACTION

Q.—I happened to find a lower impacted third molar in my jaw and had it extracted with considerable difficulty. It had to be chiseled out and the dentist used procaine. The extraction required two and one-half hours, after which pus flowed out of cavity, and I took many pieces of dead bone out of the sore for two months afterwards. Three and one-half months have passed since the extraction, and all this time there has been partial anesthesia of my tongue on the side from which the tooth was extracted, and of my gums on the inside of the jaw clear around to the centrals. My tongue has been so swollen all this time and had so little feeling in it that on two different occasions I bit it severely, the sore leaving a hard, white lump and a burning reddish patch clear to the tip of my tongue. It seems to feel fair in the morning after an all night rest but as soon as I do much talking my tongue begins to swell and tingle or feels sore and dry, and at times it just seems as if I cannot stand this any more. I have been told that possibly in six months or a year it will pass off. Shortly after the extraction the tip of my tongue irritated me almost beyond endurance as it felt as though the end or tip had neuralgia. It was one of the most terrible sensations I have ever experienced. Was this trauma caused by the forceps pinching the nerve, or was it caused by the procaine? I have extracted thousands of teeth in the last thirty-two years and never had such an experience in my own practice—I am wondering now if a cancer might be developing where I bit my tongue.—B.M.B., D.D.S., South Dakota.

A.—Your letter describes an all too familiar condition, and that you in your practice have escaped any similar results all these years, is indeed remarkable.

Even fully erupted mandibular third molars frequently lie so close to the inferior dental canal that the simple extraction of such a tooth results in a paresthesia or anesthesia of the tissues supplied by the inferior dental nerve, usually anterior to the mental foramen. We also have those cases in which the inferior dental nerve passes through a groove in the root of the third molar or even through a hole in the root or between the roots. In any one of these cases there is almost sure to be an anesthesia fol-

lowing the removal of such a tooth.

Then, in the case of the impacted mandibular third molar, wherever there has to be a good deal of bone work done, the nerve is frequently traumatized by the instruments in the course of the operation. I suspect this latter condition was developed in your case. Following injury to the inferior dental nerve we may have any one or any combination of the following conditions: anesthesia, paresthesia, or hyperesthesia. You seem to have had a combination of all three, which would indicate a rather severe injury to the nerve trunk, but probably not a complete severance. Therefore, you may expect a regeneration of this nerve and a return to normal in the course of time. Because of your age and the severity of the injury, I would anticipate that the return to normal would be delayed beyond a year. Just how much beyond, of course, I cannot say. It is generally considered that there is not much to be done to hasten repair. However, we seem to have had some results with the use of the high frequency current. At least it would do no harm to try it.—GEORGE R. WARNER

●

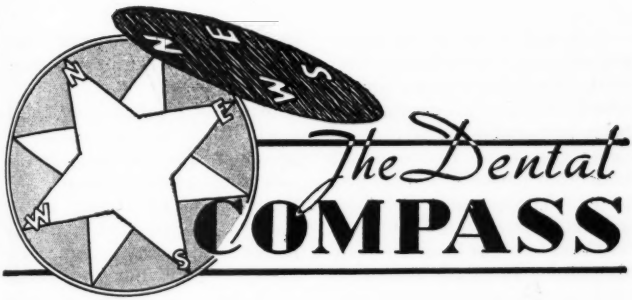
SWELLING BELOW EAR

Q.—A patient presented himself at my office with this history. About six weeks ago, at meal time, he developed a considerable swelling below the ear which disappeared two hours after the meal.

This past week he has had no less than six such attacks which I wish to summarize briefly: Swelling occurs on the left side below the ear at about the angle of the ramus, occurs only during meal time and is entirely gone two hours after the meal; swelling is characterized by no pain whatsoever. My diagnosis leads me to believe that there is a partial closure of Stenson's duct leading from the parotid gland, at the time of its greatest functioning which results in that swelling.

Kindly inform me if I am right and, if so, what treatment will relieve this condition. If I am wrong please correct me.—E.G.H., D.D.S., Wisconsin.

A.—It seems to me that you are entirely right in your diagnosis of the condition of this patient. The only thing that I can think of that might account for these swellings is a small calculus in Stenson's duct which acts something like a ball valve. This might be demonstrated by laying a film inside of the cheek and then taking a roentgenogram with a very soft exposure. The truth or the falsity of this hypothesis might also be demonstrated by passing a probe into the Stenson's duct. Of course it might be that there is something wrong with the innervation of this duct so that it is closed by spasm, but in the absence of any history of an injury or of any serious general nervous condition, I would be inclined to think it mechanical rather than nervous.—GEORGE R. WARNER



OPPOSE STATE MEDICINE

Determined to fight State medicine in Nebraska, dentists, physicians, nurses, and druggists are organizing in Omaha to combat legislative encroachments on the rights of the medical and dental professions, according to a story in a recent issue of *Drug Topics*. Each of these groups will work separately but will have a similar objective.

The dentists are planning to form an organization much like the one already developed by the druggists who have selected a committee of five. Each of these committee members will appoint majors, captains, and team members from among the members of the new organization. Everyone of the majors will be asked to contact ten personal friends and persuade them to vote against any form of State medicine which may be suggested.

At a meeting held last month, Doctor R. W. Fouts, chairman of the special committee appointed by the physicians, called the possibility of State medicine "a menace," and added that, "No one knows whether the State will try to have State insurance or State medicine, but if we are going to have to deal with these things the condition must be met by thinking men."

•

DENTAL RELIEF IN THE UNITED STATES

Activities of the several states in the matter of dental relief, as of August 1, were reported in detail in the American Dental Association Bulletin for August, 1934. The bulletin, which is issued by the Committee on Dental Economics of the Association, points out that the work of the Federal Emergency Relief Administration has been increased greatly by the drought and by the necessity of assuming the responsibility in a number of states owing to the complete breakdown of the state relief work. The report urges state society officers to meet with the officials of the state FERA and assist them in their work.

Although many of the states are carrying on extensive relief work, there are twenty-one in which no committee has yet been appointed by the local dental societies to cooperate with the national relief program. Those states in which special committees are now working in conjunction with the FERA in giving dental relief to the unemployed are: Washington, Oregon, California, Montana, Wyoming, Utah, New Mexico, South Dakota, Nebraska, Texas, Michigan, Wisconsin, Illinois, Missouri, Mississippi, Tennessee, Alabama, Ohio, Pennsylvania, New York, New Jersey, Maryland, Massachusetts, and New Hampshire.

In the absence of a local committee dentists in Rhode Island are giving their services individually to provide for treatments for indigents. Negotiations are in progress in Kansas where a fee scale has been adopted by the state society and presented to the FERA; and Indiana is also developing plans for giving dental service to those on relief rolls.

As to the District of Columbia the officers of the Dental Society and the local FERA administrators have agreed upon the following plan: The members of the Dental Examining Board of the District of Columbia are to administer their relief. Needy dentists are to be employed fifteen hours a week in their own offices, for which they will be paid $21.06 weekly. This is the same hourly rate paid regular half-time school dentists.

Methods for handling relief work differ in various states. Missouri, for instance, has a special plan of its own. The State Board of Dental Examiners has appointed a deputy in every county, and these members form the state dental committee in charge of relief work which is cooperating with the FERA. According to a committeeman of that state, this plan has not only promoted efficiency in the handling of the dental relief services, but it has given an impetus to organized dentistry in Missouri. So impressed have dentists been by the fact that there is a deputy in each county, the membership in dental organizations has increased in seventy-two counties from thirty to one hundred per cent.

A comparison of the fees charged for relief work in the several states reveals some disparity. The range of fees asked for typical services follows:

Examination	$1		
Full mouth x-ray	3	to	$15
Single films	.50	to	2
Fillings	1	to	6
Extractions	.50	to	3
Surgery and extractions	10	to	20
Dentures	20	to	35
Repairs of dentures	1	to	5
Relief of pain	1	to	3
Root canal therapy	2	to	10
Prophylaxis	2	to	4
Pyorrhea treatments	2	to	5

DID MONA LISA NEED A DENTIST?

Kees Van Dongen, Dutch artist and a noted judge of modern beauty, thinks so. When talking to a reporter for the International News Service recently, he said, "Mona Lisa must have had bad teeth. That's why she has such a pinched and strained look."

With little regard for Leonardo Da Vinci's world famous painting Van Dongen expressed the opinion that Mona Lisa's enigmatic smile was more practical than artistic. "I believe," he said, "that Mona Lisa's puzzling smile came because she really did not want to open her mouth. Even in those days, when there were no dentists, perfect teeth were requisite to beauty."

●

"GOLD MINING" CHECKED

Dentistry has become a "gold mine" for somebody. In Braddock, Pennsylvania, a group of children discovered what they consider a lucrative mine in the yard just behind the offices at 721 Braddock Avenue that have been occupied by dentists for about fifty years, first by Doctor J. R. King and at present by his nephew, Doctor Robert E. King. Year after year the women who did the cleaning in the offices have been throwing gold scrapings and pieces of crown and inlay into the yard. Enterprising children have been digging these up and selling them for several weeks, in fact ever since a heavy rain first uncovered a bit of gold. One of the most successful of the miners is said to have realized the sum of $6.50 from his diggings. Fear that this continual probing may undermine a brick wall and cause a "mine" disaster has prompted the Braddock police to curtail the activities of the children.

●

NEW YORK DENTIST WINS TITLE

Shooting under the colors of the Bradford, Pennsylvania, Gun club, Doctor Irving N. Troup, Olean, New York, retained his American dental trapshooting championship when he made a score of 96 out of a 100 at the Twin City Gun club, St. Paul, Minnesota.

The three who tied for runner up honors were: Doctor G. H. Jones, Duluth; Doctor J. F. Erdman, Lakefield, Minnesota, and Doctor Charles Mills, Chillicothe, Ohio with scores of 95.

In the shoot off Jones made 24 out of 25, Erdman 23 out of 25, and Mills 22 out of 25.

The two-man state team race was won by Doctor Wm. H. Jordan and Doctor Harry Allshouse representing Missouri.

●

LAFFODONTIA

If you have a story that appeals to you as funny, send it in to the editor. He MAY *print it—but he won't send it back.*

Wife: "Do you think the mountain air will disagree with me?"

Hubby: "I doubt if it would dare, my dear."

Brown had been standing in the coal cellar for an hour with his fingers glued firmly over a leak in the water main.

Suddenly he heard his wife calling.

"George," she shouted, "you can take your hands off that leak now."

"Thank heaven!" replied her husband. "Has the plumber come at last?"

"No. The house is on fire."

Motor Cop: "I've a good notion to give you a ticket.'

Sweet Young Thing: "Oh, do! And give me one for a real good show."

Teacher: "Now, Tommy, if I take a potato, cut it in half, then in quarters, and then in halves again, what shall I have?"

Tommy: "Chips, miss."

Mr. Smith wanted to borrow a book from Mr. Jones. When he asked him, Mr. Jones said, "Yes, you may borrow a book from me if you read it in my library."

Mr. Smith was glad to read the book, but he didn't forget where he had had to read it.

As time passed on Mr. Jones was in need of a lawn mower and he decided to ask Mr, Smith for the loan of his,

"Mr. Smith, may I borrow your lawn mower?"

"Yes," replied Mr. Smith, "if you use it on my lawn."

"How are you fixed, old man?"

"For what?"

"Why-er-I'd like a loan of $10.00."

"Just right. I haven't a cent with me."

Two bankers appeared at the golden gates. St. Peter examined his records and could not find that they were entitled to admission. They insisted that the records must be wrong. St. Peter finally agreed to go inside and examine another set of records. When he returned both the bankers and the golden gates were gone!

First Business Man: "Your new stenographer is a beauty. Can she spell?"

Second Ditto: "Does it matter?"

Gold Digger: "Thank you so much for this lovely pearl necklace."

Married Man: "Don't mention it, don't mention it, don't mention it!"

Rum Runner: "Them's the chief's orders. Slow your truck down to eight miles an hour and let the stuff age!"

Sick Man: "Doctor, the other doctors seem to differ from you in their diagnosis of my case."

Doctor: "I know, but the post-mortem will show which of us is right."